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September 1958

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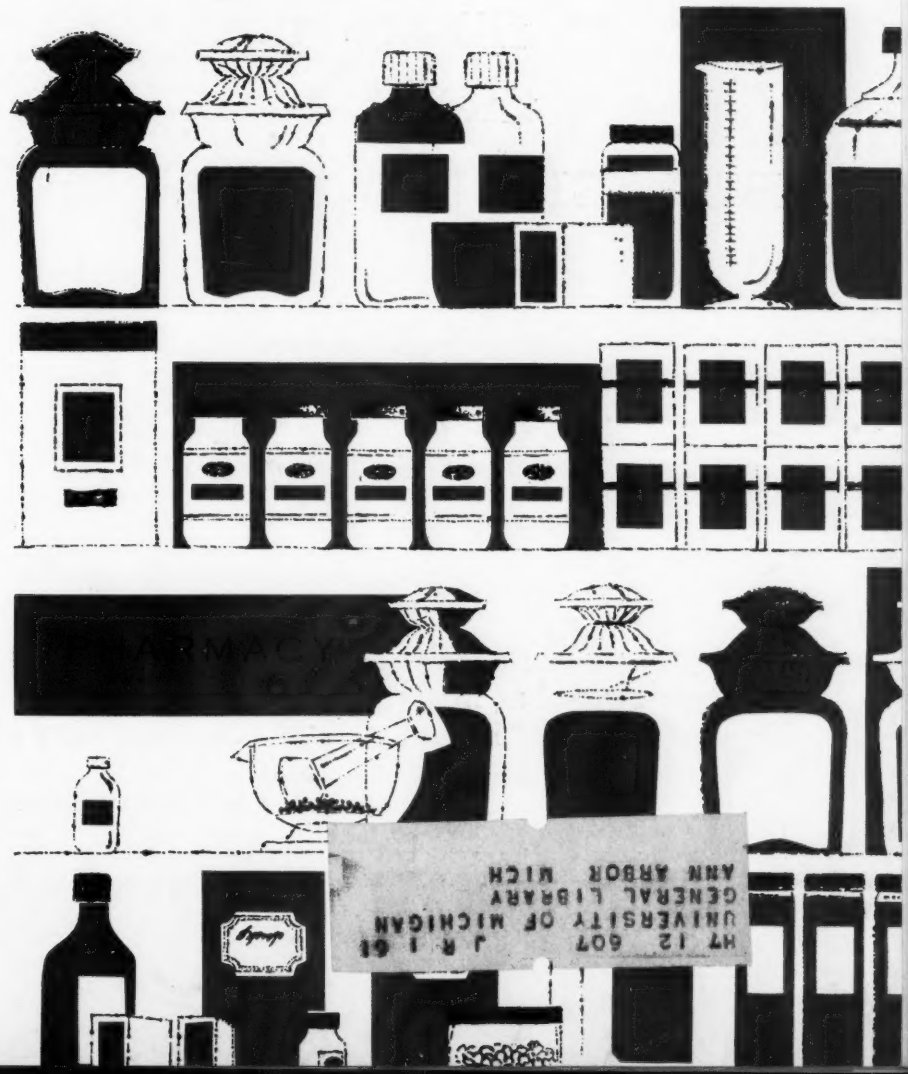

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Small Hospitals' Clinic

Small Hospital Pharmacy and the Administrator

by Rocco C. Mittica
Administrator
Rockingham Memorial Hospital
Bellows Falls, Vermont

■ THE ADMINISTRATOR'S most difficult task is to develop and maintain an efficient internal organization of employed personnel. To achieve this, he must endeavor to assemble a group of well-qualified department heads. Some services, however, will require closer attention in management than others. The pharmacy in the small hospital is one of these services. The possible course that the administrator may establish in improving this service may be one of the following three recommended solutions.

1. Employ a full-time pharmacist.
2. Utilize the local pharmacist.
3. Establish a Pharmacy Committee.

The best solution will depend a great deal on the individual hospital and must be answered by each hospital administrator in his own way.

Full-Time Pharmacist

The best method for improving the efficiency of the pharmacy would be to employ a full-time registered pharmacist. Whether he would have enough work in the pharmacy is questionable. But if he has the personality and adaptability, his job can be supplemented in such areas as purchasing, central supply, and possibly as assistant administrator, which still remains to be determined as a necessity in the small hospital. The shortage of registered people to manage departments is certainly not a new problem for the adminstrator of a small hospital. Since he is faced with the problem of acquiring registered personnel for all of the established departments such as dietary, laboratory, pathology, radiology, and all other departments of the hospital, it is easy to see why he places primary importance on these established departments and not upon the pharmacy which does not exist as a department in the small hospital. But all services are equally important for efficient patient care, and the pharmacy is certainly performing its primary function of providing the patients with the drugs they need.

Utilize the Local Pharmacist

As a retail pharmacist alone, he has never been exposed to hospital problems and techniques. The choice of the retail pharmacist can be a determining factor in preserving the local hospital pharmacy. He can better the service to the patients, and also help put the hospital pharmacy on an even financial course if he has the essential abilities to work together with the physicians, nurses, and administrator. A local pharmacist will be of great value in guiding and counselling the physicians in their use of therapeutic agents, and also be of value to the administrator in the management of an efficient pharmacy. There is no doubt that such a person will be difficult to find.

Pharmacy Committee

The most important of the suggested solutions that the administrator can employ in the management of the pharmacy is the estab-

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lishment of a Pharmacy Committee. This committee, if properly organized, can develop standardization of drug inventory and usage, thus improving the efficiency and economic condition of the pharmacy service to the patients.

The committee's success depends a great deal on how well the physician, administrator, pharmacist, or retail pharmacist, realize the potential provided by the pharmacy committee and how well it informs the other groups of its functions. In the absence of a pharmacist the administrator will have to provide the stimulus necessary for the committee to carry out its purposes. This certainly is no new role for the administrator of a small hospital since the over-all responsibility of the hopsital is his. Therefore, he must be capable of performing in all phases of hospital administration.

The administrator-medical staff relationship will be a determining factor in the application of the pharmacy committee and its formulary system. The medical staff should be made to feel that the formulary they will use is a product of their own enterprise, and a list of drugs designated by themselves for their own use in their hospital. The committee cannot over-emphasize that the job is not finished once the mechanical plan is put into effect, and that the formulary must be kept up-to-date. In dealing with the doctor, the administrator and pharmacist should never try to take over the professional responsibility in the hospital. Only the doctor is qualified to make decisions regarding medical care. The application and success of the committee is proportionately related to the size of the medical staff. The degree of success may be determined by the cooperation and mutual understanding of this group.

Economy

In any hospital, the first consideration of the pharmacy department is to provide good reliable medications for the patient. Medicines are tools of the physicians. Success in his profession depends upon what he prescribes. The patients in our small hospitals are being supplied with the drugs they need so that the problem is primarily one of saving the patient money.

Economy of operation is an important but secondary goal. The reduction of cost in the hospital is a joint enterprise. The administrator and the pharmacist cannot look to the doctor, nor can the doctor look to the administrator and pharmacist, for absolute control of costs. Only by cooperation and mutual understanding will they effect such control.

Economy of operation depends on the success of the Pharmacy Committee. If it is successful in standardization of drug inventory and usage, the paying patient will undoubtedly benefit in quality, safety and economy. Whether the committee succeeds in standardization or not, the primary function of providing the patient with the drugs they need will not be changed.

Consultation by a pharmacist in the small hospital would be of great value to the physician, but as long as the supply continues to linger behind the demand, the small hospital must utilize the best possible means available to provide this service. The use of the retail pharmacist and establishment of a Pharmacy Committee certainly will improve the efficiency and economy of the pharmacy service, and should be considered seriously for adoption by small hospitals.

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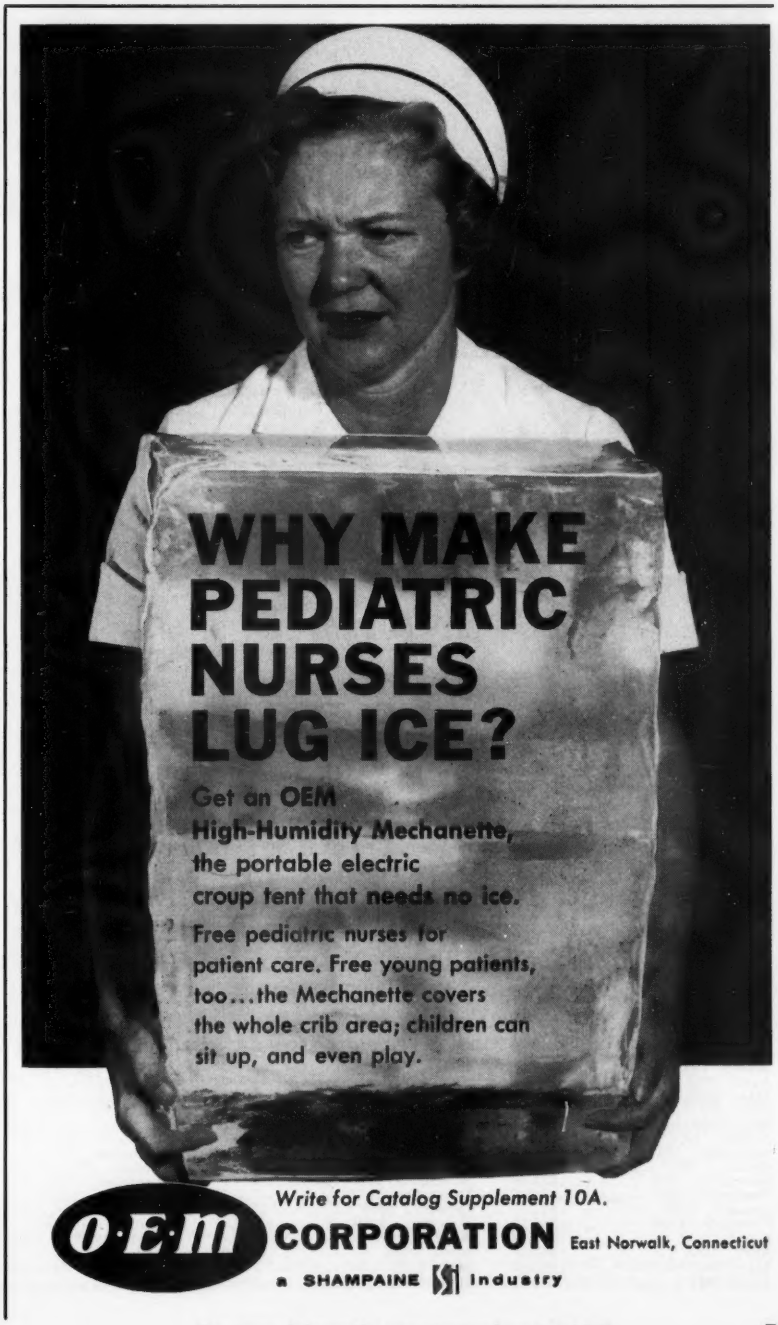
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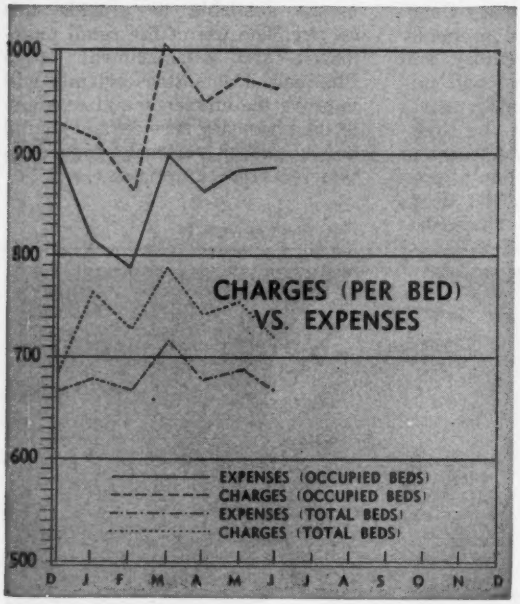


■ Microfilming of medical records is a common practice in hospitals. Microfilming of financial records is common in business and industry. But microfilming of accounting and financial records is rare in hospitals. Only 12% of our sample reported that they microfilm financial records.

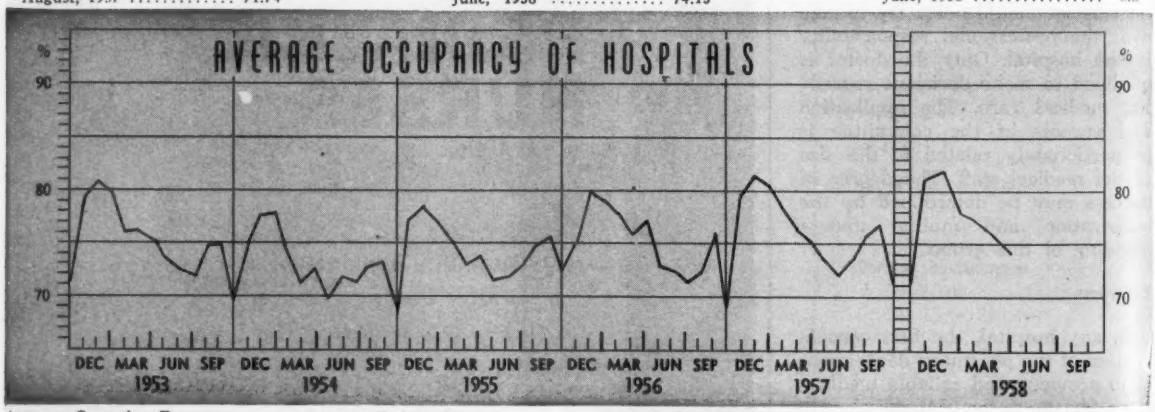
Certain records one year or older are microfilmed by 7 per cent of our sample and a few only microfilm certain very old records. The practice of microfilming financial records is one that should be studied carefully by all hospitals. ■

Average Monthly Occupancy
(on 100 percent basis)

November, 1956	75.32
December, 1956	69.33
January, 1957	79.10
February, 1957	81.39
March, 1957	80.32
April, 1957	78.06
May, 1957	76.31
June, 1957	75.01
July, 1957	73.51
August, 1957	71.74
September, 1957	73.41
October, 1957	75.36
November, 1957	76.62
December, 1957	71.31
January, 1958	80.98
February, 1958	81.97
March, 1958	77.84
April, 1958	77.20
May, 1958	76.10
June, 1958	74.15

Average Length of Patient Stay
(in days)

August, 1957	6.5
September, 1957	6.6
October, 1957	6.8
November, 1957	7.2
December, 1957	6.7
January, 1958	6.9
February, 1958	6.9
March, 1958	6.8
April, 1958	6.6
May, 1958	6.7
June, 1958	6.3



Average Operating Expenses Per Occupied Bed Per Month

December, 1956	847.59
January, 1957	758.42
February, 1957	726.55
March, 1957	769.40
April, 1957	797.89
May, 1957	832.42
June, 1957	811.77
July, 1957	888.34
August, 1957	865.78
September, 1957	871.78
October, 1957	848.22
November, 1957	823.20
December, 1957	893.31
January, 1958	811.72
February, 1958	788.06
March, 1958	896.46
April, 1958	862.87
May, 1958	885.02
June, 1958	888.85

Average Patient Charges Per Occupied Bed Per Month

December, 1956	863.70
January, 1957	848.47
February, 1957	791.38
March, 1957	869.32
April, 1957	890.09
May, 1957	908.42
June, 1957	878.46
July, 1957	946.87
August, 1957	928.94
September, 1957	907.22
October, 1957	926.28
November, 1957	874.64
December, 1957	925.98
January, 1958	918.10
February, 1958	862.21
March, 1958	1003.77
April, 1958	950.00
May, 1958	971.78
June, 1958	960.07

Average Operating Expenses Per Bed Per Month (Total Beds)

December, 1956	593.85
January, 1957	611.86
February, 1957	603.97
March, 1957	627.86
April, 1957	634.15
May, 1957	644.97
June, 1957	624.23
July, 1957	660.06
August, 1957	646.84
September, 1957	658.71
October, 1957	646.16
November, 1957	641.89
December, 1957	660.84
January, 1958	675.67
February, 1958	665.96
March, 1958	700.18
April, 1958	678.17
May, 1958	686.88
June, 1958	666.07

Average Patient Charge Per Bed Per Month (Total Beds)

December, 1956	610.55
January, 1957	685.17
February, 1957	655.93
March, 1957	707.78
April, 1957	702.84
May, 1957	700.34
June, 1957	679.76
July, 1957	703.33
August, 1957	690.35
September, 1957	682.08
October, 1957	705.02
November, 1957	682.03
December, 1957	680.84
January, 1958	761.39
February, 1958	727.50
March, 1958	784.75
April, 1958	743.49
May, 1958	754.21
June, 1958	719.44

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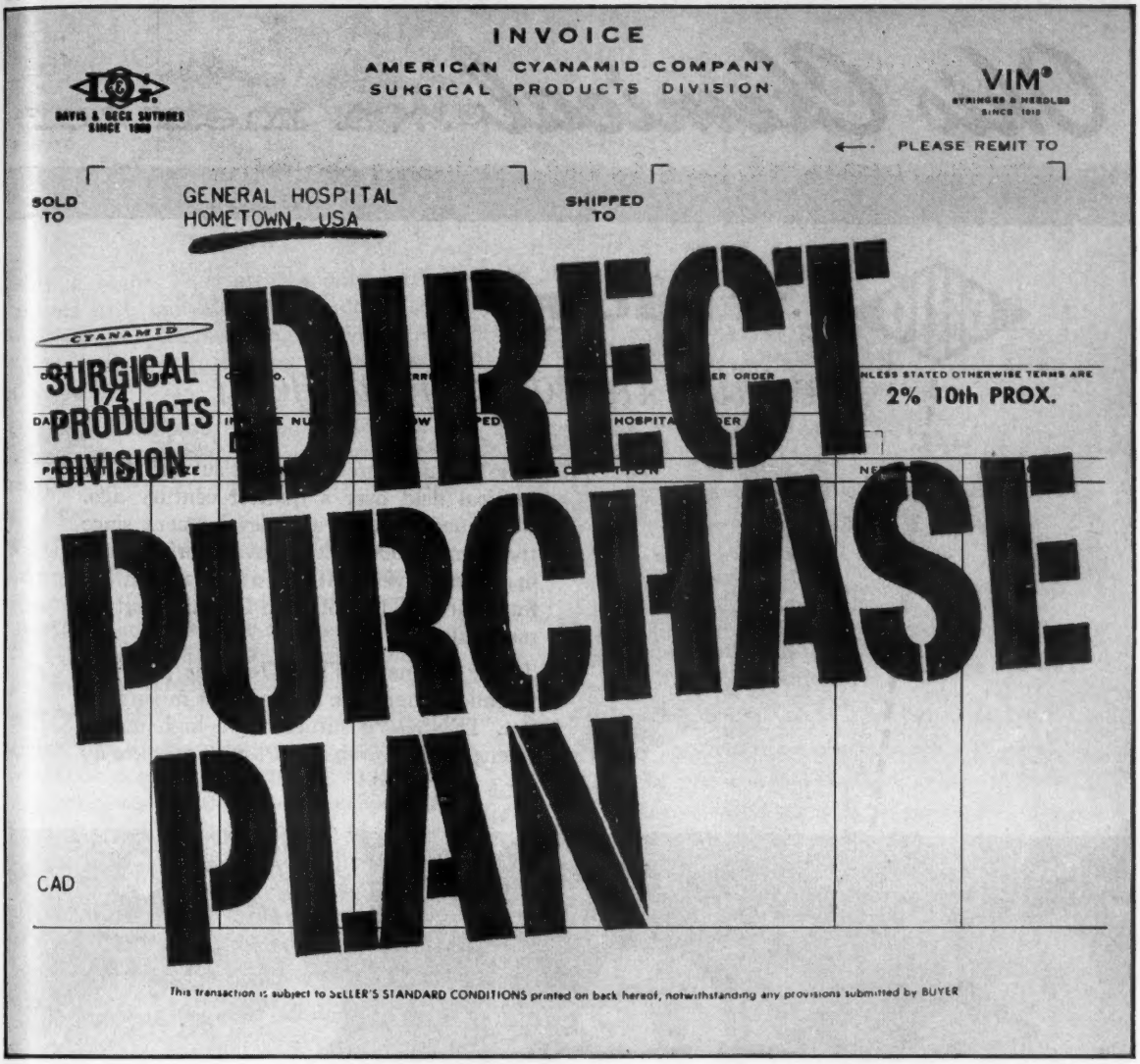

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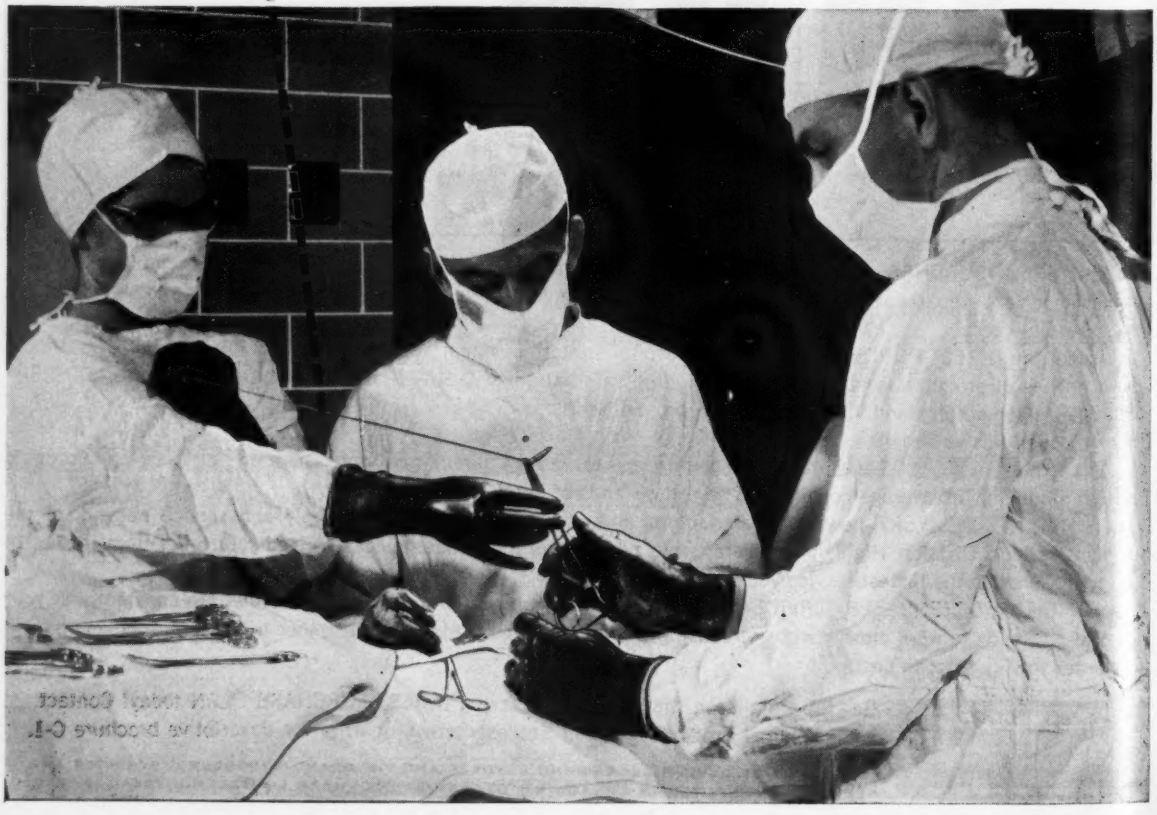

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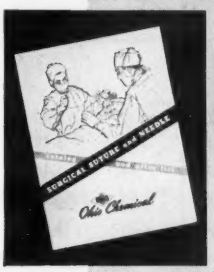

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June 1958 Regional How's Business Report

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NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,629	3,854	8,181	1,111	4,043	9,669	1,556	3,310	12,997	1,742	3,513	6,558
% of OCCUPANCY	77.30	80.03	83.52	60.33	80.07	85.42	69.80	77.53	79.45	73.57	68.98	70.21
EXPENSES BY DEPTS. Per Patient Day												
Administration	4.01	3.96	4.74	4.24	3.64	3.49	2.47	2.95	2.96	2.98	3 38	3.52
Dietary	3.77	4.05	4.39	4.29	3.87	3.36	3.00	3.18	3.39	3.11	3.10	3.06
Housekeeping	1.07	1.68	2.33	1.34	1.33	1.40	.90	1.14	1.30	1.05	1.17	1.40
Laundry	.98	.65	.63	.63	.76	.56	.51	.49	.80	.69	.58	.41
Plant Operation	1.47	2.53	2.55	2.22	1.90	1.82	1.53	1.64	2.12	1.66	2.16	1.77
Medical & Surgical	1.07	1.42	2.30	1.28	1.50	1.48	1.07	1.19	2.58	1.03	1.74	5.11
O. R. & Del. Rms.	2.64	2.18	2.33	1.58	1.68	1.33	1.34	1.58	2.07	2.28	1.60	3.00
Pharmacy	1.13	1.37	1.09	1.14	1.24	1.18	1.23	1.58	1.28	1.48	1.40	1.76
Nursing	8.62	7.27	7.98	8.31	8.12	6.39	5.18	6.19	6.21	5.50	7.02	3.49
Anesthesia	.54	.97	1.17	.89	.39	.70	.63	.47	.59	.69	.80	1.08
Laboratory	1.56	2.26	3.09	1.46	2.06	1.65	1.22	1.77	1.93	1.59	2.30	2.22
X-ray	1.95	1.69	1.61	1.68	1.51	1.23	1.51	1.83	1.65	1.47	1.65	1.45
Other expenses	1.15	.62	1.73	.51	.94	1.46	.57	.49	1.90	.56	.75	.82
TOTAL EXPENSES	48,577	119,144	304,459	32,416	117,725	261,408	32,470	80,050	382,105	41,413	97,178	192,003
TOTAL CHARGES TO PATIENTS	51,053	135,525	312,578	32,596	125,424	293,926	35,291	87,031	402,521	43,402	94,891	219,859
OPERATING INCOME PER PATIENT DAY	31.34	35.16	38.21	29.34	31.02	30.40	22.68	26.29	30.97	24.91	27.01	33.53
OPERATING EXPENSES PER PATIENT DAY	29.82	30.91	37.22	29.18	29.12	27.03	20.87	24.18	29.40	23.77	27.66	29.28

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan, Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,368	3,260	8,689	897	3,099	9,192	699	2,970	8,740	687	3,259	6,339
% of OCCUPANCY	75.07	75.19	86.11	65.88	72.23	82.96	50.40	73.88	85.68	47.30	72.11	86.60
EXPENSES BY DEPTS. Per Patient Day												
Administration	3.22	3.04	3.03	2.42	2.62	3.21	3.78	3.47	2.60	6.16	5.16	4.73
Dietary	3.29	3.50	3.58	3.00	3.38	3.32	3.19	6.00	3.58	4.99	4.60	3.65
Housekeeping	1.46	1.32	1.37	.74	1.10	1.51	1.09	1.54	.98	1.87	1.97	1.76
Laundry	.74	.68	.67	.66	.70	.48	.71	.91	.53	1.15	1.12	.80
Plant Operation	2.15	1.98	1.81	1.71	1.93	1.95	1.70	1.40	1.24	3.05	1.91	2.53
Medical & Surgical	1.25	1.39	2.15	1.50	2.16	1.89	1.77	1.70	1.67	2.92	2.31	2.33
O. R. & Del. Rms.	1.77	1.56	1.57	1.25	1.94	2.11	1.42	2.62	1.72	3.38	3.56	3.60
Pharmacy	1.37	1.44	1.39	1.40	1.16	1.44	1.40	2.61	1.63	2.01	2.23	1.62
Nursing	8.19	6.74	6.71	6.95	6.07	6.25	7.14	9.66	6.41	14.56	10.86	10.18
Anesthesia	.90	.43	.27	.34	.30	.98	.47	.72	.16	.09	.60	.34
Laboratory	1.45	1.84	1.83	1.26	1.42	1.96	1.85	2.84	2.21	3.81	3.12	3.08
X-ray	1.60	1.69	1.33	.96	1.38	1.42	1.81	1.83	1.49	3.30	2.23	2.63
Other expenses	.25	.35	1.12	.33	.45	.50	.71	.31	.37	1.49	1.00	.93
TOTAL EXPENSES	36,769	85,324	231,089	19,423	77,696	253,265	17,872	106,275	216,452	33,469	130,777	243,999
TOTAL CHARGES TO PATIENTS	39,135	91,917	260,527	19,590	80,899	271,419	18,088	121,393	232,996	29,545	134,341	269,365
OPERATING INCOME PER PATIENT DAY	28.61	28.20	29.98	21.84	26.10	29.53	27.04	40.87	26.66	43.01	41.22	42.49
OPERATING EXPENSES PER PATIENT DAY	26.88	26.17	26.60	21.65	25.07	27.55	26.72	35.78	24.77	48.72	40.13	38.49

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Hospital Accounting

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Allocation of Costs

Inquiry: *In reading about methods of allocation of costs in determining the cost of routine and special services in a hospital, nothing has been found about factors to be considered in choosing a basis for allocation of costs. What are some of the factors to be considered?*

Comment: Presumably authors of articles and even of handbooks on cost allocation for hospitals have considered their problem sufficiently complicated without attempting to discuss the theory or principles involved in choosing a base for allocation of costs. In commenting upon factors to be considered in the choice of a basis for allocating costs, at least one fundamental principle should be expressed. That one principle is that whatever basis is selected, for example square feet of space, there should be a direct relationship between the basis unit (square feet in this instance) and the expense incurred. The test of such a relationship is found in an analysis which indicates whether cost does increase in proportion to the increase in the number of square feet of space. Some such relationships are obvious. For instance heating cost has a direct relationship to square feet of space and an even closer relationship to cubic feet of space. It is not so obvious that administrative expenses are incurred in direct relation to the number of employees, the amount of payroll, or the employee hours in a department. However the bases referred to are frequently used for cost allocation purposes. Some short cut allocation methods distribute all nonrevenue producing department costs to the revenue producing departments on the basis of total costs already incurred in the department to which the allocation is being made. This appears to be an arbitrary basis, and usually is arbitrary, in that no analysis is made to find out whether there is any direct relationship between the total amount of costs incurred within the department and the amount of nonrevenue department costs which are incurred on behalf of that department. If the revenue producing department does not actually cause nonrevenue producing department costs to be incurred in direct relationship to cost incurred in operating it, then total expense incurred in the revenue producing departments is an arbitrary and meaningless basis for allocation of nonrevenue producing department costs. ■

Inquiry: *When a hospital is on the accrual basis of accounting, is it a serious divergence from that basis to keep the payroll on a cash basis, that is, to omit accrued payroll at the end of the period for which financial statements are being prepared?*

Comment: If each month contained the same number of pay days, recording payroll on the cash basis would have little effect upon the accuracy of the financial statements. However, in practice some months have an extra payroll payment which will have considerable effect upon the statements for those months and a lesser effect on the other months. Since the 365-day year does not divide up equally into months with an equal number of weeks each, weekly payroll periods end near the close of a month on any day from the twenty-fifth of the month to and including the sixth of the following month. Thus, as many as six days and as few as one day of the payroll period may have elapsed without recognition in the expenses of that month. This indicates the inaccuracies created by following the above practice. The only thing that can be said in defence of the procedure is that many hospitals and a great many business establishments use it and do not consider it a serious handicap in the use and interpretation of the financial data presented at the end of an accounting period. This is probably because they have tight control over payroll and readily understand the fluctuations from period to period caused by these payroll fluctuations. ■

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Insurance Investigator

QUESTION: *When a patient died recently an insurance investigator demanded to examine the medical record of the deceased previous to the terminal admission. The purpose of his examination was to see if the deceased had reported suffering from illness prior to the time that she took out the insurance policy. The authorization was signed by the spouse of the deceased after her demise. Upon our refusal to show the patient's record, the insurance investigator threatened to withhold payment of the life insurance until he saw the record. What is our obligation in this case?*

ANSWER: Obviously, the insurance investigator was hoping to find grounds for refusing payment of the life insurance. While a hospital should not condone fraud, it is not obliged to throw open its records to an insurance company so as to enable it to prepare a case against the estate of the deceased.

The hospital records are maintained for the purpose of administrative control as any other records are maintained by institutions.

If the insurance investigator wants to obtain confidential information revealed by the patient to her physican, he should approach the physician and not the hospital. If the physician refuses to disclose the information, certainly there is no reason why the hospital should frustrate the professional secret that exists between the doctor and patient.

If the insurance company refuses payment, the heirs of the deceased can always have recourse to legal action against the insurance company.

Departmental Standing Orders

QUESTION: *The heads of our clinical departments insist that they are the final authority in setting up standing orders for patient treatment in their own departments. This has created some conflict with the general practitioners in particular, who feel that no standing orders should be adopted by any department head without reference to the medical staff and to the governing body. Is this correct?*

ANSWER: The general practitioners are right. It is a fundamental principle of hospital organization that no orders or regulations can be imposed upon the physicians who practice in the hospital, unless they have beeen approved by the governing body. The proper procedure is as follows:

1. Standing orders should be formulated by the department head after consulting with members of his department, including doctors, nurses and other interested parties.
2. These orders should be submitted to the administrator who should call in other department heads to see in what manner the standing orders may affect other departments and what modifications might need to be made.
3. After consideration by the administrator and department heads, the standing order should be referred to the executive committee of the medical staff and by them to the entire medical staff, if the standing orders appear to be controversial.
4. The standing orders are then referred to the governing body for approval or rejection.
5. If standing orders are rejected they should be discussed by the joint conference committee whose medical staff members should then confer with the original department head who submitted them.
6. When approved by the governing body, the standing orders become the law of the hospital and are handed to the administrator and to the department head for enforcement.

Active Staff Membership

QUESTION: *There are five hospitals in our town. All of the doctors are on the active staff of all of the hospitals. They now complain that they have to attend too many meetings. They propose that medical staff meetings should be joined together and rotated through each of the hospitals at monthly intervals. Our board does not feel that it would be in the best interests of our hospital. Can you advise us?*

ANSWER: It would be most improper to conduct combined meetings. A doctor may be on the active staff of several hospitals but he is an active member in name only. He has the status and rights of active membership but does not have time to carry out the duties and responsibilities of membership.

A doctor cannot divide his primary loyalties between several hospitals. Eventually his duty to one must conflict with his duties to the others and his allegiance will be directed to the hospital of his first choice.

Active staff membership imposes important responsibilities upon the physician. These are to attend regular staff meetings, to participate in committees, to be on the duty roster for emergency service, to perform administrative duties and to hold office on the medical staff. Doctors are like other people. All of us like to enjoy the rights and the authority but we are less receptive to the duties and responsibilities.

It is not right for a doctor to enjoy active staff privileges but to assume only courtesy staff duties in return.

You should consult with the administrators of the other hospitals and work out a roster so that a physician holds active staff membership only in one hospital and courtesy privileges in all of the others. In this way each doctor will have privileges corresponding to his duties.

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1. Bacala, J.C.: The Use of the Systemic Hemostat, Carbazochrome Salicylate, West J. Surg. *64*:88 (1956).

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Guest Editorial

Tuberculosis — The Current Situation

James E. Perkins, M.D.
Managing Director
National Tuberculosis Association

The continuing but largely hidden mass of tuberculosis infection has been compared to that of an iceberg. When the mountain of ice towers above the water the danger to ships is obvious to every lookout and every radar beam. As it drifts southward in warm currents the treacherous underwater mass becomes not only difficult to detect from above but its presence is also rare enough to dull the lookout's vigilance.

This same kind of illusion is now distorting our perspective on tuberculosis.

As tuberculosis deaths have decreased and the demand for hospital beds has shrunk slightly under the impact of specific drug treatment the true state of affairs has not been generally appreciated. The common and accepted measurements of the significance of a disease do not tell the whole story. In plain view are the 90,000 cases reported in 1956, the 150,000 active cases under some kind of supervision, and we are not unaware of the 14,000 deaths each year. But these figures fail to reveal the 50 to 55 million persons in our population infected with virulent tubercle bacilli, the 100,000 additional active cases which exist but have not been reported and the additional 1,750,000 people who have had active tuberculosis in the past and who are thereby subject to a significant risk of relapse. The long sustained decrease in new cases reported annually and the more rapid drop in mortality in recent years have been interpreted erroneously as forecasting an early end to tuberculosis as an important problem.

It is now becoming evident that the bulk of new active cases occur in persons who have been infected for some time. This deduction is consistent with the observed shift in the distribution of new cases to the older ages where infection rates are higher. It is generally believed that these high infection rates are residuals from earlier years when the disease was more prevalent and opportunities for infection more frequent. As long as there are millions of infected individuals, a significant number of new cases will develop each year even if no new infections were taking place. New case reports have continued as before with only a small reduction each year.

In spite of an extensive search by several pharmaceutical concerns, costing millions of dollars, no new major drugs have come to light since 1952. Streptomycin, isoniazid, and para-amino-salicylic acid (PAS) remain the only standard antimicrobial drugs in general use. Pyrazinamide, viomycin, cycloserine, streptovaricin, have all been of value in patients who for some reason have not been able to continue on the standard regimens, but they are either too toxic or lacking in effectiveness to be considered for standard therapy. Two new drugs, kanamycin and thiocarbamidin, are now under clinical study but both will probably be of secondary value. Thiocarbamidin does show some promise as a replacement for PAS which many patients are unable to take because of the gastrointestinal symptoms it produces.

All drugs in use at present are only partially bactericidal and exert their beneficial effects primarily by inhibition of growth. They must be used in combination or the bacilli soon lose their susceptibility and the drug becomes ineffective. This resistance by the infecting organism to the action of drugs seems to develop more rapidly and surely in advanced lesions with tissue destruction and cavity formation.

However, there are many who are of the opinion that one of the drugs, isoniazid, can be used alone in spite of its rapid loss of effectiveness in test tube cultures. For one thing, minimal disease is often brought under control before resistance has time to develop. For another, the organisms often seem to lose some of their virulence when they become resistant to this

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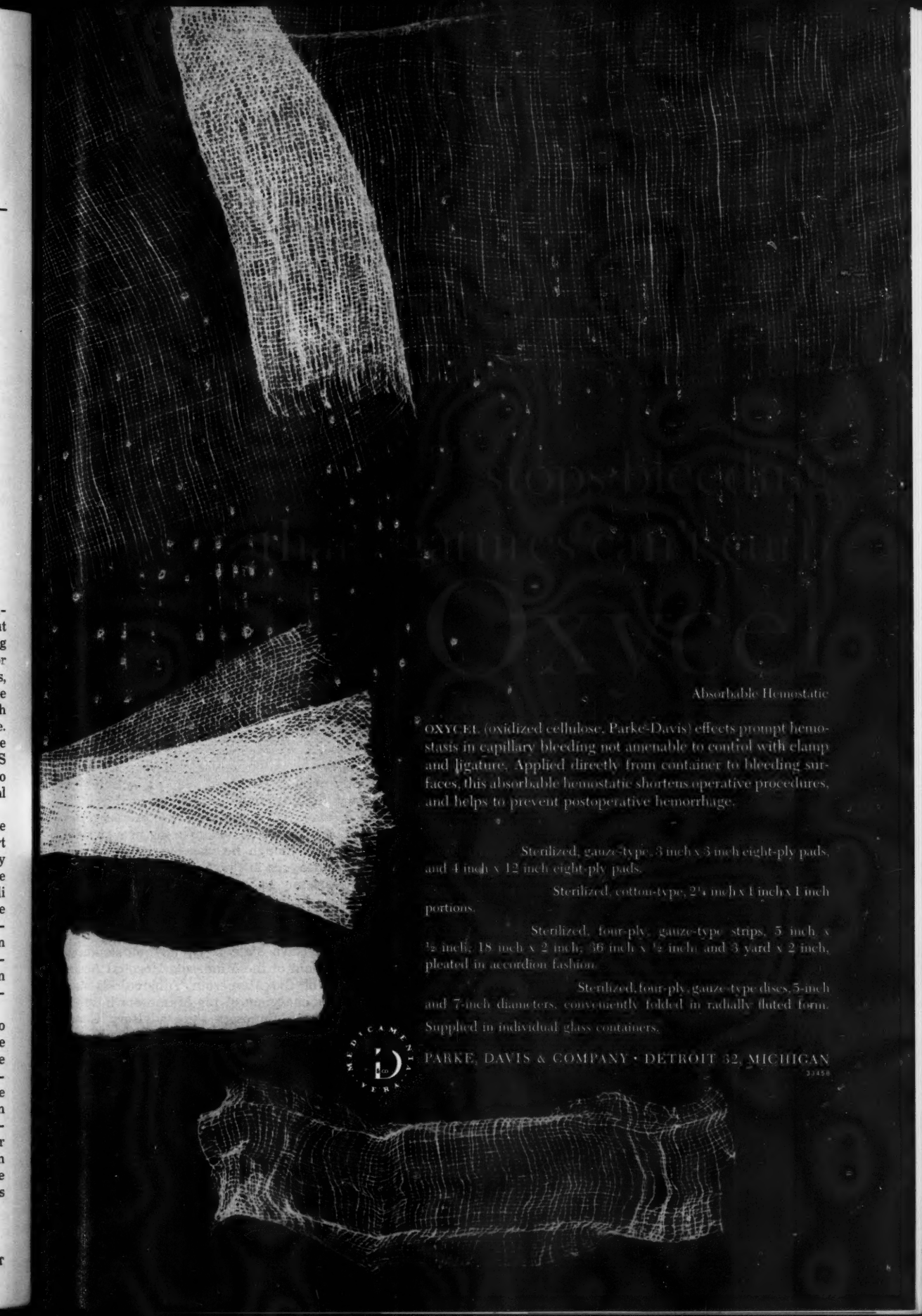

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President
American Hospital Association

■ RAY AMBERG is the sixtieth president of the American Hospital Association. He is serving for the year 1958-1959. He is superintendent and director of the University of Minnesota Hospitals, a post which he has held for some 23 years. He is a man of deep conviction, a staunch Roman Catholic and a straightforward, articulate man who says what he thinks is right and makes decisions without fear or favor. He has served the hospital field long and well.

He is a true member of the profession of hospital administration. He participates actively in teaching young hospital administrators both as professor of hospital administration in the school of public health of the University of Minnesota and as a preceptor who is one of the highly regarded mentors in the field of education for hospital administration. The profession looks up to him as a fine example of what an administrator ought to be.

He was a charter fellow of the American College of Hospital Administrators and has served both as regent and as vice president of this august body. Like so many of the great administrators of his time, Ray Amberg was not formally trained in hospital administration but grew into the profession.

Born in St. Paul, Minnesota, in 1895, Mr. Amberg studied pharmacy at the University of Minnesota and received the degree of Ph.C. in pharmacy from this institution. Almost immediately he became the pharmacist of the University and from then on his ability in administration earned for him rapid promotion in hospital administration.

He became assistant hospital manager of the University of Minnesota Hospitals in 1924, hospital manager in 1929, assistant director in 1932 and director in 1935.

Ray Amberg has contributed greatly to the improvement of patient care in hospitals. His participation on the councils of the various hospital associations has helped hospitals to raise their standards. On the national level he has been active in the American Hospital Association as a member of its House of Delegates, its Council on Government Relations, Council on Professional Practice. He has also been a trustee of the Association.

In his Association work on the national level things have not always been sweetness and light with Ray Amberg. He never hesitated to voice his opposition to some apparently popular course of action if he felt that it was contrary to the best interests of the hospitals everywhere. A long range thinker, Ray Amberg has been rewarded on many occasions by being proven right over the years even though he was overruled by the majority of his colleagues in the Association. Ray Amberg stood up fearlessly to the best of them sometimes gaining, sometimes losing the point but always in fair, open and above board in the presentation of his point of view.

His record in his own state is equally outstanding. He served as president of the Minnesota Hospital Association, president of the Minnesota Tuberculosis and Health Association, chairman of the Minnesota hospital construction program, Minnesota state advisory Committee on Nursing and a member of the Advisory Committee to the Minnesota state board of health on hospital licensure and the health committee on registration of hospital administrators. He was a member of the Governor's Committee on the Handicapped in 1944. In addition he is a member of numerous organizations in the health, hospital and paramedical fields.

Facing enormous association problems in his year of tenure, Ray Amberg can be counted upon to do his own thinking and to come up with the right answers as he has demonstrated so ably in the past. HOSPITAL MANAGEMENT takes this occasion to salute Ray Amberg and to wish him well in his forthcoming responsibility. ■

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Infections in Hospitals

by Kenneth B. Babcock, M.D.

■ THE PRESENCE of infections in hospitals of various kinds will always be with us and we must accept it. To keep these infections to an absolute minimum is of paramount concern to all. This can be done only through continuous education and re-education of *all* hospital personnel, to carry out known control methods with strict discipline at all times.

The Commissioners of the Joint Commission on Accreditations of Hospitals think that the matter is of such grave importance that they urge hospitals to study their own problem and set up systematic controls. The Commission cannot dictate what these controls should be. However, this Bulletin suggests an approach which might be used as a pattern. Each hospital should develop its own methods of study and control to meet its specific needs.

Committee on Infections

The Commissioners recommend that every hospital have an "Infection Committee" charged with the responsibility of investigation, control and prevention of infections within hospitals. Membership on this committee should include the medical staff, administration and nursing service personnel. Where possible, participation with community health organizations such as health departments, medical societies and hospital councils is recommended, because the problem is not necessarily confined to the hospital itself. The responsibility of the committee can appropriately include the following:

A. Establishment of definite controls. Control measures must have validity.

B. Establishment of techniques for discovering infections on patients who have left the hospital.

1. Trace source of infection for which a patient may be admitted.
2. Periodic sampling by letter, card, call or visit of discharged patients.

C. Make certain that bacteriologic services in or out of the hospital are available.

D. Establish a system of reporting all infections among patients and personnel and keep records as a basis for studying the source of infections.

Review Existing Practices

A. Clean and aseptic techniques should be practiced on all services of every hospital at all times. This includes the following procedures involved in patient care:

1. Re-check all dietary and food handling procedures, such as proper dishwashing techniques, preparation and disposal of food, refrigeration, sanitation of ice bins, and the disinfection of contaminated utensils and equipment. There should be a special technique for infected or "isolation" patients.

2. Review laundry practices. This involves linen control, blanket control, special technique in handling and disposal of contaminated laundry in patients' rooms, nursery, operating room and the laundry itself.

3. Study carefully methods of handling and disposing wastes and excreta of sputum, feces and urine, and the environmental wastes of dressings, floor sweepings and food.

4. Re-study traffic controls and visiting rules in all areas, especially in operating rooms, nurseries and on obstetrical floors. They must be kept at an absolute minimum. Diligent maintenance of general cleanliness in all areas of the hospital, especially in service areas like utility rooms, janitors' closets, trash closets.

5. Check sources of air pollution. Air conditioning and ventilating units should be inspected regularly for contamination through intake sources, screens and filters (wet or dry). Hospital floors and corridors must be considered as potential spreaders of infection. Wet mopping is far preferable to dry sweeping. There should be a definite practice established for the care and cleanliness of the mop after each usage; a dirty mop spreads infection.

6. Routine, periodic culturing of autoclaves and water sterilizers, which is a must for all hospitals.

B. Educate and orient all personnel in the practice of aseptic techniques. An informed worker is a better and a safer worker. It is especially important that physicians not consider themselves the exception to the rule, but both teach and set a good example for all. There can be only one accepted standard of practice. The following practices are some which should be studied:

1. Hand washing and scrubbing practices with review of proper soaps and detergents. Sinks with foot or knee controls in operating rooms, nurseries and isolation rooms are especially vital.
2. Proper gown techniques.
3. Proper mask techniques.
4. Proper dressing cart techniques and procedures.
5. Proper packaging of all goods, materials and instruments for steam sterilization.
6. Proper packing of autoclaves. No autoclave should be so tightly packed that the packages are either tight together or tightly pressed against the walls. It is especially important that all impervious containers such as cans, jars, test tubes and deep trays be so placed in the autoclave that they lie on their sides, or with the opening downward, which prevents the trapping of air and failure of sterilization at the bottom of the container. Improper packaging and improper packing by unskilled people can undo the finest autoclaving precautions.

Control Use of Antibiotics

The medical profession has become increasingly aware of the problems created by the routine and indiscriminate use of antibiotics. Hospital surveys by the Commission reveal that the infection rate in most hospitals using antibiotics routinely is higher than in those not doing so. The common denominator in hospital infections appears to be the resistance of bacteria to antibiotics used on the individual case. From this, the conclusions drawn are that this increase in infections is due to the routine, indiscriminate use of preventive antibiotics in the absence of infection, and the indiscriminate use of antibiotics in the presence of infection without preceding cultures and sensitivity tests. In this latter type of case it is more than useless since without an adequate antibiotic, one may only inhibit the infectious agent and also at the same time stimulate the growth of other

Please turn to page 132

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1. Hunter, J.A., et al.: Hosp. Management 81:82 (March) 1956, 81:80 (April) 1956, 83:86 (March) 1957. Reprints are available from your Wyeth Territory Manager or write Wyeth, P.O. Box 8299, Philadelphia 1, Pa.

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Continued from page 18

particular compound, and patients usually do not regress when continued on treatment as they do when resistance develops to other drugs. These observations have led to the use of isoniazid alone in situations where outpatient oral therapy of large numbers of patients is the only practical program. The general institution of such programs in areas of high tuberculosis prevalence is accompanied by some apprehension that many new infections will be taking place with resistant organism unresponsive to the most effective drug now known.

Two trends in the chemotherapy of tuberculosis have become conspicuous in recent years. One is the use of larger doses, particularly of isoniazid, in the first few weeks of treatment. The other is an ever extending duration of treatment. Two- to four-year courses of treatment are not uncommon, and in patients who have more extensive lesions, chemotherapy is being urged with no definite termination date. From limited data, it appears that long term continuous therapy does reduce the relapse rate.

Surgery these days is largely excisional for the purpose of removing destroyed portions of the lung, although collapse procedures, such as thoracoplasty, are employed when lesions are too extensive for excision or other indications make it too risky. Pneumothorax and pneumoperitoneum are seldom used except under unusual circumstances. Surgical excision of small non-cavitary residual lesions is practiced less frequently now that some preliminary observations seem to show no difference in relapse rates in patients who were not operated upon.

The need for rest in the treatment of tuberculosis is well established, particularly when symptoms are present. However, there is a considerable difference of opinion concerning the degree of activity which should be allowed the convalescent. The tendency is to be more liberal than in the past, and some patients with minimal lesions who are non-infectious are allowed to work while continuing on long-term courses of drug therapy. Efforts are being made to assess the results under varying rest regimens but the extreme variability of other factors make such studies difficult.

The introduction of effective long-term antimicrobial drug treatment has had a marked effect on the efficiency of hospital bed use. In most institutions for tuberculosis treatment the necessary length of hospital stay for the average patient has been reduced to something like seven to ten months and as a result fewer beds can accommodate the same number of patients. However, most authorities agree that adequate and successful therapy depends on an initial hospital stay for diagnosis, observation, necessary surgery and protection of the public from this communicable disease.

This reduction in bed needs has often been misinterpreted as an indication of a rapid fall in the number of new cases. The true picture is well illustrated by this quotation from a note in the *Journal of the American Medical Association* for April 19, 1958:

"*Decrease in Number of Tuberculosis Patients* — A 16 percent decrease in the average daily number of tuberculosis patients in VA hospitals since 1954 was re-

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IT'S THE IMPROVED R36 50cc. CONTROLLED VOLUME PEDIATRIC UNIT. . . NOW IT'S CALLED PEDATROL, AND EACH OF THESE SEGMENTS HOLDS EXACTLY 10ml.
AND WE THOUGHT THE OLD R36 WAS THE LAST WORD IN ACCURACY.
ACTUALLY IT WAS . . . UNTIL PEDATROL CAME ALONG WITH THIS SEGMENTED CHAMBER. YOU CAN SET ANY DOSAGE FROM 10ml. TO 50ml., SIMPLY BY CLAMPING BETWEEN THE COMPARTMENTS.
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ported March 11. The daily average dropped from 15,221 in fiscal year 1954 to 12,715 in fiscal year 1957, *although the number of admissions and discharges of patients with tuberculosis over the same period of time remained the same.*"

This phenomenon coupled with the slow gradual fall in the number of new cases has produced some acute problems in some states where surplus tuberculosis beds became a financial problem. If the surplus is real and not the result of poor case finding and other control measures, the tendency has been to close the small custodial-type outlying institutions and concentrate patients in larger more centralized hospitals. In other cases, well-equipped hospitals have been authorized to accept patients with other pulmonary diseases or chronic diseases. Another obvious solution is to admit tuberculosis patients to special sections established in general hospitals. But this has not been popular due apparently to an unreasonable fear of the disease on the part of both administrators and staffs. That this can be done successfully has been demonstrated in several places. Some suggestions for dealing with these difficulties in tuberculosis hospital bed logistics have been incorporated in a statement by an American Trudeau Society Committee published in the November 1957 issue of *The American Review of Tuberculosis and Pulmonary Diseases.*

The type of patient being treated in hospitals has also been changing. Every tuberculosis hospital annual report emphasizes the continuing shift to an older average age and to a predominence of male patients. Another less widely appreciated fact is the high proportion of patients who have had a previous period of hospital treatment. This often runs in the neighborhood of 30 percent. These retreatment cases are relapses, of course, and as a group they represent the most difficult patients with which a hospital has to deal. They are likely to have advanced disease with organisms resistant to drugs, many are alcoholics, and they are prone to leave before their treatment is completed.

The shorter length of hospital stay and the treatment of some patients entirely outside the hospital has brought about a necessity for readjustment of the provision of special as well as medical services. In most of the larger hospitals adequate medical and nursing services are provided and a good start has been made on rehabilitation services. The shift toward more treatment at home caught most communities unprepared with a shortage of outpatient services. This need is still not being met. Inadequate or nonexistent health department clinics, a shortage of public health nurses, a lack of provision for free drugs, and little provision for rehabilitation, are common in many areas of the country. From large-scale sampling studies, it appears that only about half of the known patients are in hospitals and a large proportion of those at home (20 per cent) are not even under medical supervision. As long as this situation continues the treatment of patients and the application of control measures will fall far short of the effectiveness which could be achieved.

The mainstay of tuberculosis prevention and control remains the finding and maintenance under treatment of as many as possible of the patients who have active disease. This involves the examination and supervision of all patients and their contacts and a further search

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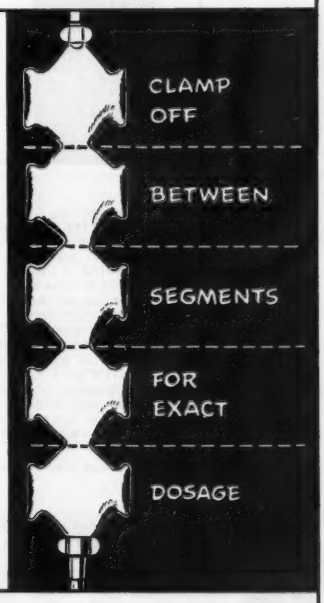

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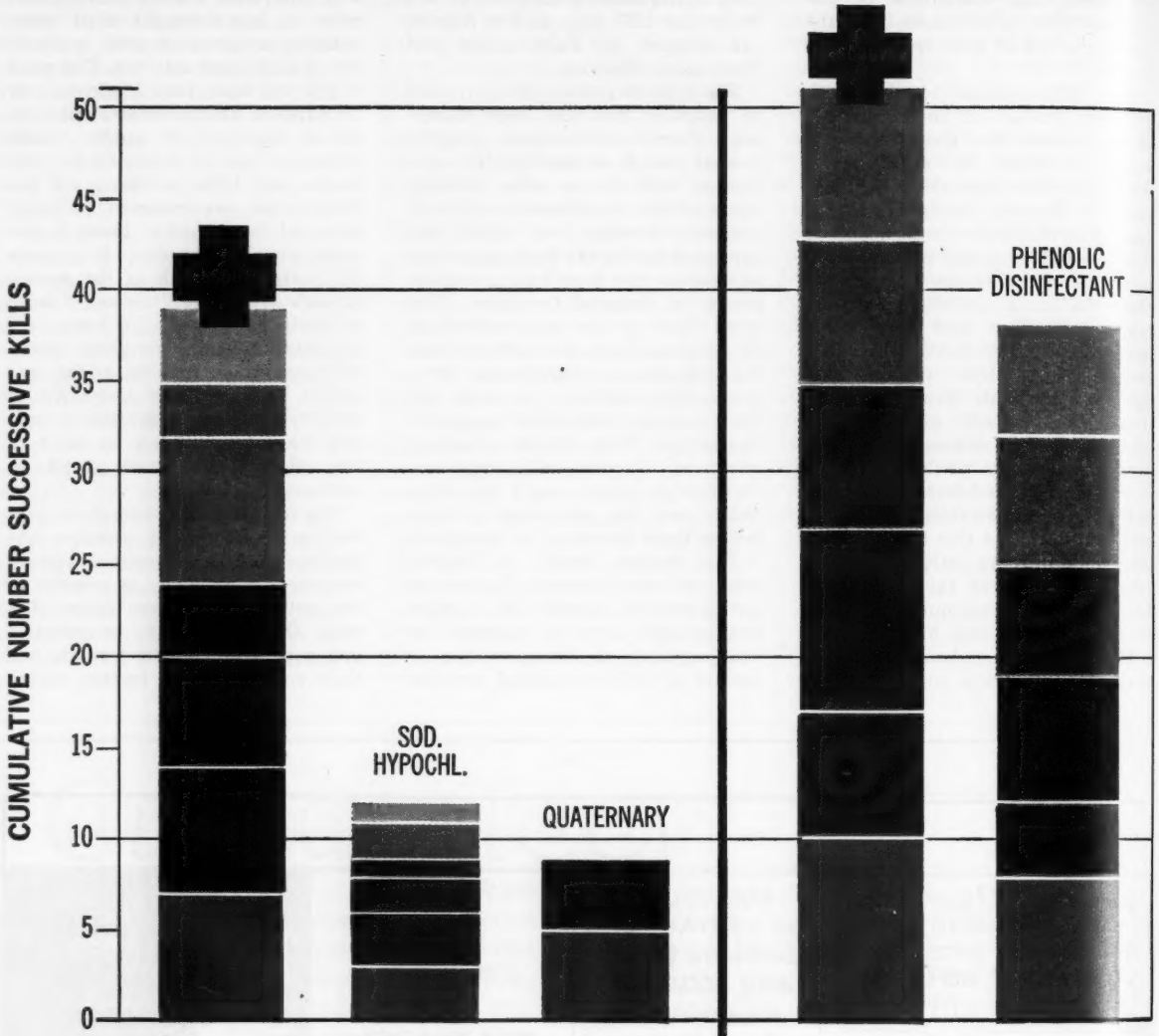
TESTS SHOW GREATER



Capacity Test for Germicidal Action. (A. Cantor and H. Shelanski as described in Soap and Sanitary Chemicals, February 1951.) **Explanation:** This method essentially consists of adding to the use-dilution of the disinfectant or sanitizer, successive doses of a 50/50 mixture of milk plus broth culture of test organisms. These doses are added at ten minute intervals. Thirty seconds after each addition, a transfer is made into broth containing a suitable inactivator. This method makes it possible to determine the capacity of a germicide to kill before the micro-organisms and organic contamination have exhausted its germicidal action. **Organisms:** Salmonella typhosa, ATCC #6539; Micrococcus pyogenes. var. aureus, ATCC #6538; Salmonella pullorum, ATCC #9093; Pseudomonas aeruginosa, ATCC #8689; Trichophyton interdigitale Emmons 640, ATCC #9533; Penicillium luteum, ATCC #9644; Saccharomyces cerevisiae, ATCC #10274. **Dilutions:** WESCODYNE: 1:320 (50 ppm available iodine); Sodium hypochlorite: (100 ppm available chlorine); Quaternary: (50%) 1:5,000 (200 ppm active ingredient). **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, USP XIII was used for testing WESCODYNE and sodium hypochlorite "Letheen" broth was used for testing alkyl dimethyl benzyl ammonium chloride.* All tests were re-subcultured in the same medium. **Results:** See above chart. **Conclusion:** The cumulative number of successful kills shows WESCODYNE to be over three times more effective than the nearest material tested.

*Neopeptone dextrose broth was used for testing the alkyl dimethyl benzyl ammonium chloride against the three fungi.

Wescodyne vs. Leading Phenolic Disinfectant. (A. Cantor and H. Shelanski Capacity Test as described in Soap and Sanitary Chemicals, February 1951.) The method used in this test is the same as that used in the Capacity Test for Germicidal Action described at left. **Dilutions:** WESCODYNE: 1:213 (75 ppm available iodine); phenolic disinfectant: 1:100 **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, U.S.P. XIII was used for testing WESCODYNE and FDA nutrient broth was used for testing the phenolic disinfectant. All tests were re-subcultured in the same medium to eliminate bacteriostasis. **Results:** see above chart. **Conclusion:** This test shows that the bactericidal effectiveness (in the presence of organic contamination) of WESCODYNE at a dilution of 1:213 (75 ppm available iodine) is greater than that of a leading phenolic disinfectant at a dilution of 1:100.

PATHOGEN COLOR KEY:

- Salmonella typhosa (typhoid organism)
- M. pyogenes v. aureus (staphylococcus organism)
- Salmonella pullorum (poultry disease organism)
- Pseudomonas aeruginosa (wound contaminent organism)
- Trichophyton interdigitale (athlete's foot type of fungus organism)
- Penicillium luteum (mold organism)
- Saccharomyces cerevisiae (yeast organism)
- Strep. pyogenes hemolyticus (streptococcus organism)
- Escherichia coli (enteric organism)
- Shigella sonnei (dysentery organism)
- Salmonella schottmuelleri (food contaminent causing dysentery)

GERMICIDAL CAPACITY

WESCODYNE's advantages for the destruction of "Staph" as well as other disease producing organisms are extraordinary. Its greater germicidal capacity is shown at left. Two other features are equally outstanding:

❶ Nonselective biocidal activity offers wide-spectrum effectiveness — greater than that offered by solutions containing chlorine, cresylics, phenolics or quaternaries. It destroys organisms that range from mold to bacteria, viruses, spores and fungi. Antibiotic resistant strains of Staph are killed in 2 minutes at the general-purpose use dilution of 75 ppm available iodine.

❷ Labor-saving detergent action removes soil and dust as germs are destroyed. This simplifies procedures, including those for the control of dust that carries Staph and other organisms.

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for new patients by tuberculin test and x-ray. These measures can and do reduce the number of new infections but, of course, cannot prevent the new cases which develop from old infections. Since the number of new infections is comparatively small these days, the real problem in the future will be to eliminate the infections which have already occurred or to find some way of preventing their development into active disease. Efforts in this direction show some promise. In the December issue of *The American Review of Tuberculosis and Pulmonary Diseases* the United States Public Health Service reports a reduction of 80 percent in the incidence of tuberculosis complications in children with primary tuberculosis treated with isoniazid. And studies are now in progress to test the feasibility of isoniazid as a prophylaxis measure among the contacts of tuberculosis cases.

Tuberculosis is still a major problem all over the world while undergoing a slow decrease in prevalence. With one-third of our population infected in this country, no sudden disappearance of this disease can be expected since we have no direct method of predicting or preventing the development of a sizable number of these infections into active disease every year. This persistence of the infection, analagous to that of some weed seeds which remain alive in the soil for many years, explains the peculiar resistance of tuberculosis to the usual communicable disease control measures. With the passage of enough time tuberculosis should reach the vanishing point, but thousands of people will be disabled and thousands will die of tuberculosis over future decades unless the weapons for attacking this disease are markedly improved. ■

A Hospital Prayer

■ Almighty God, our heavenly Father, who didst send thy Son, Jesus Christ, to be the Savior and Healer of men; bless, we beseech thee, this hospital and its work; to those who serve, give wisdom and skill, tenderness and strength; to those who are ill, give patience and courage and the recovery of health; and grant that in every hour of trial we may know that thou are near, and put our whole trust in thy goodness and mercy, in the name of thy Son Jesus Christ, our Lord. Amen. ■

—*Tacoma General Topix.*

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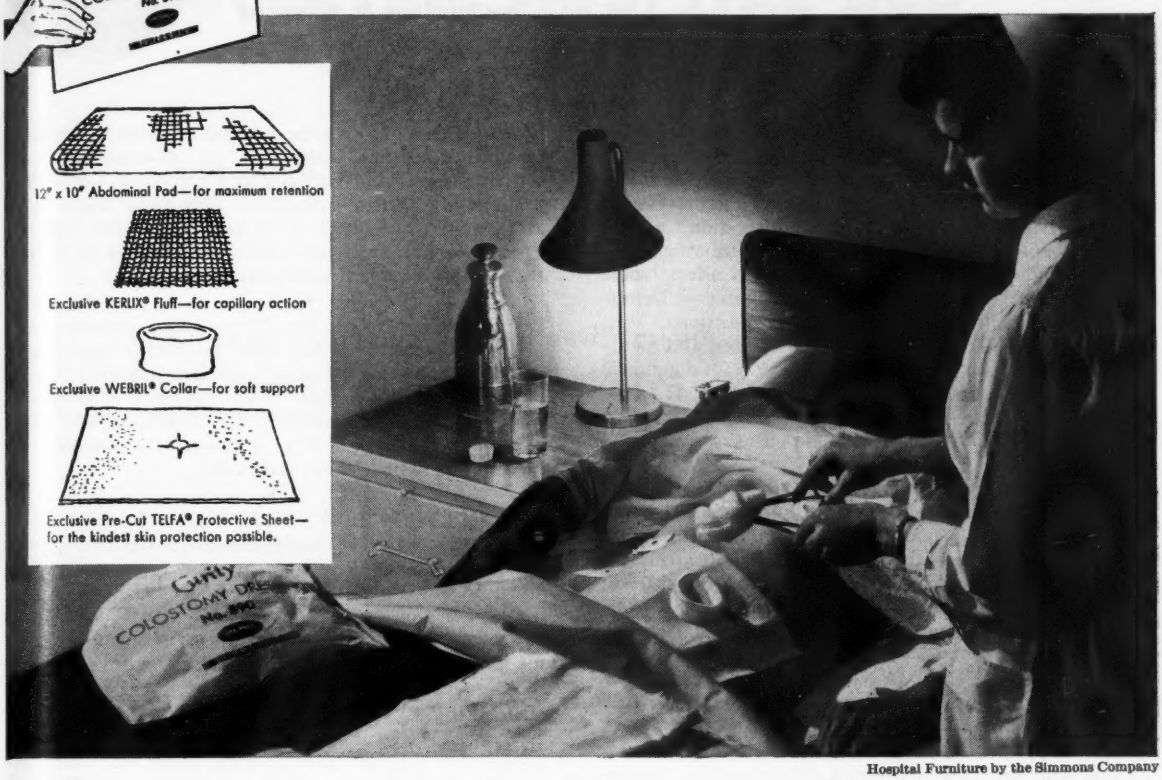

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Washington Bureau Reports

by Walter N. Clissold

FINAL H-B APPROPRIATIONS totaled $186.2 million —less than we predicted last month, but better than the $75 million originally asked by the Administration, or the $121.2 million initially appropriated by the House. Why the Senate version of $211.2 million didn't hold is anyone's guess. Perhaps the mid-east situation, and possible higher military spending had an effect; some point out the H-B cuts were in the categories—a Democrat Congress clipping a Republican proposition.

Here's the breakdown, in millions: hospital and medical center construction, fully authorized $150; diagnostic and treatment centers, $7.5; chronic hospitals, $7.5; rehabilitation facilities, $10; $10 for nursing homes, research, $1.2. H-B salaries and expenses were upped slightly, to $1.6.

Other items in HEW's overall fiscal 1959 appropriations, of interest to hospital people: Food and Drug Administration, $9.8; Construction of Indian health facilities, $4.124; National Library of Medicine construction, $6.950; construction of general office building at NIH, $9.625. Appropriations for the institutes of NIH, $294.383, up from $211,183 last year.

•

THE "BAPTIST BILL," providing for federal loans for construction of hospitals and other facilities under title VI of the PHS Act, is now law. It will enable Baptists, who asked for and plumped for it, and other religious groups who are now prevented (church-state separation principle) from accepting grants, to participate in the Hill-Burton program. Loan applications will be treated the same as requests for H-B grants, will come out of regular H-B allotments, subject to state agency and PHS Surgeon General's approval. Interest rates will be fixed according to a formula and, in effect, be a little higher than the going rate for U. S. government obligations at the time. Forty years will be maximum.

•

LOAN APPROVALS — *Small Business Administration:* $90,000 to Raymond Hospital & Clinic, Johnstown, Pa.; Anthony (nursing) Home, Macon, Ga., $77,200; Wrightwood (nursing) Home, Chicago, $100,000; Thomas E. Doyle (nursing home), Chicago, $10,000; Wahpeton (N. D.) Rehabilitation Center, $135,000; Helgeson Nursing Home, Sauk Rapids, Minn., $20,000; Hamilton County (Tex.) General Hospital, $75,000; Arcade Hospital, N. Sacramento, Calif., $196,000; R. J. Salter (nursing home), New Meadows, Idaho, $20,000. *Community Facilities* Administration: Methodist Hospital, Madison, Wisc., $250,000. living accomodations for student nurses, director of nursing, and two house mothers; Hendricks County, Ind., an advance of $55,094 to finance preparation of complete plans for the construction of a 65-80 bed general hospital a mile east of Danville; Doctor's Hospital, Columbus, Ohio, $115,000 for an apartment building to house 14 married intern families.

•

RECESSION SPAWNED loan fund, Community Facilities Act of 1958, which would have provided money for both private and public hospitals, looked as if it were dying—and might even be dead by the time this reaches you. House Rules Committee, an all-powerful body, sent it back to the Banking and Currency Committee. Even if the Rules Committee objections were to be straightened out, there were still differences with the Senate version to compromise—and, on top of all that, there was hinted a Presidential veto.

•

$1 BILLION A YEAR BY 1970 — that is what a special group of consultants to HEW Secretary has recommended should be spent on medical research. But, to be effective, the eminent body suggests, will require major increases in number of physicians and other scientists working in this area—not to mention the facilities in which they may labor.

•

PHS SG LEROY E. BURNEY, M.D. — honored by the Washington Board of Trade and the District of Columbia Medical Society at a testimonial luncheon, for the accomplishments during his term as SG to date, and for his election as president of the 11th World Health Assembly. Some suspect a future invitation to WHO to meet in the nation's capitol, again.

•

FARMERS' EXPENDITURES FOR HEALTH CARE in 1955 included some $150 million paid directly to hospitals, and another $200 million spent on health insurance. Boils down to $31 per family for hospitals; $42 for health insurance.

•

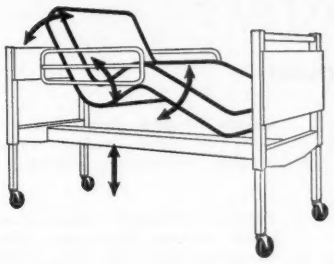
NATIONAL HEALTH SURVEY discloses that the people of the United States average about 16 days of restricted activity each, per year, due to illness or injury. Some 5.5 of these days are bed-disability days. No data is given as to how many, if any, of these bed-disability days are spent in hospitals.

•

PEOPLE — *Dr. Jack C. Haldeman,* who succeeds *Dr. Vane H. Hoge* as chief of the Div. of Hospital and Medical Facilities (where H-B headquarters) at PHS, was in on the very beginnings of H-B 'way back in '46 as executive officer (chief administrative officer) of the program. He's a native of Enid, Okla.; received his M.D. from the U. of Okla. in 1937; has served, among other places, in Puerto Rico and Alaska . . . CORRECTION. *Dr. Hoge* becomes executive director of the Hospital Planning Council of Metropolitan Chicago on Sept. 15. (Our Chicago sources failed us in filling in this information correctly in last month's item.) . . . *Robert E. Ansheles,* former legislative assistant to *Sen. Ralph E. Flanders* (R., Vt.), has been named legislative liaison officer of HEW, succeeding *John Ryan McKenzie,* resigned . . . *George T. Daughters* has been appointed chief of the new Detroit District of FDA . . . *Gilbert R. Barnhart* is now chief of the Div. of Research Grants and Demonstrations of the Office of Vocational Rehabilitation, per *Miss Mary E. Switzer,* director of OVR

■

American
ELECTRIC HOSPITAL BED



The bed with 8 distinct motorizing actions and push-button patients' control

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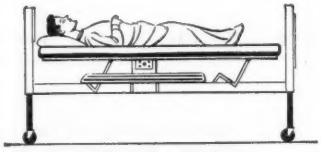
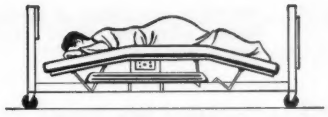
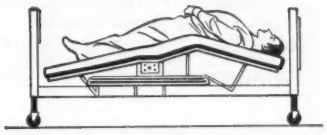


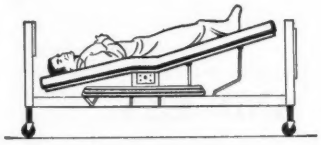
HIGH PRONE POSITION



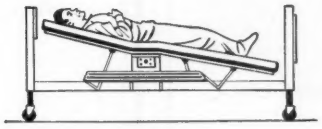
REVERSE SPINAL POSITION



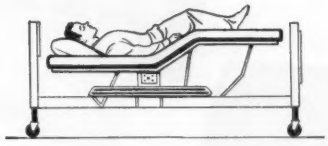
SPINAL HYPEREXTENSION



TRENDELENBURG POSITION

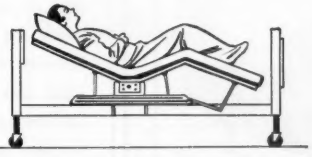


REVERSE TRENDELENBURG (Head Traction) POSITION



VASCULAR POSITION

HIGH FOWLER POSITION



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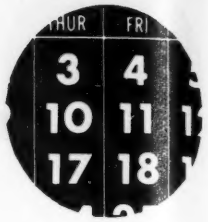
Hospital Calendar



September

8-11 . . American Nursing Home Association, Sheraton Palace Hotel, San Francisco, California.

18-19 . . American Osteopathic Hospital Association, Northwest Institute, Multnomah Hotel, Portland, Oregon.

24-25 . . Southwestern Pennsylvania Hospital Accountants Association and the Hospital Council of Western Pennsylvania, Roosevelt Hotel, Pittsburgh, Pennsylvania.

24-26 . . Florida Chapter of the American Association of Hospital Accountants and the Florida Hospital Association, Helen Hamil, Chapter Secretary, Mercy Hospital, Miami, Florida.

28-30 . . American Association of Hospital Accountants, Traymore Hotel, Atlantic City, New Jersey.

October

8- 9 . . Indiana Hospital Association, Indiana University Student Union Building, Indianapolis, Indiana.

8- 9 . . Vermont Hospital Association, Hotel Vermont, Burlington, Vermont.

9-10 . . Colorado Hospital Association, Cosmopolitan Hotel, Denver, Colorado.

13-14 . . Oregon Association of Hospitals, Gearhart Hotel, Gearhart, Oregon.

13-16. . . American Association of Medical Record Librarians, Statler Hotel, Boston, Massachusetts.

15-16 . . Washington State Hospital Association, Winthrop Hotel, Tacoma, Washington.

20-21 . . Idaho Hospital Association, Elks Temple, Boise, Idaho.

21 . . Hospital Association of Rhode Island, Sheraton-Biltmore Hotel, Providence, Rhode Island.

21-24 . . The American Dietetic Association, Benjamin Franklin and Bellevue Stratford Hotels, Philadelphia, Pennsylvania.

23-24 . . Mississippi Hospital Association, Hotel Heidelberg, Jackson, Mississippi.

23-24 . . Nebraska Hospital Association, Sheraton-Fontenelle Hotel, Omaha, Nebraska.

25 . . American College of Osteopathic Hospital Administrators, National Institute, Statler Hotel, Boston, Massachusetts.

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New Cortrophin-Zinc has received unsurpassed acceptance in hundreds of clinical patients.

****RAPID ACTION**
New Cortrophin-Zinc stimulates peak adrenal output within 2 hours.

****HIGHEST PURITY**
New Cortrophin-Zinc contains the purest commercially available ACTH, as shown in comparative studies to be published.

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New Cortrophin-Zinc provides therapeutic ACTH activity for several days (40 Units).

****INCREASED ECONOMY**
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Arthritis	Periarteritis Nodosa
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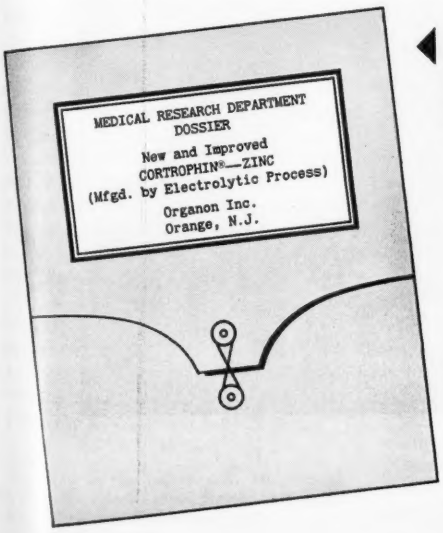

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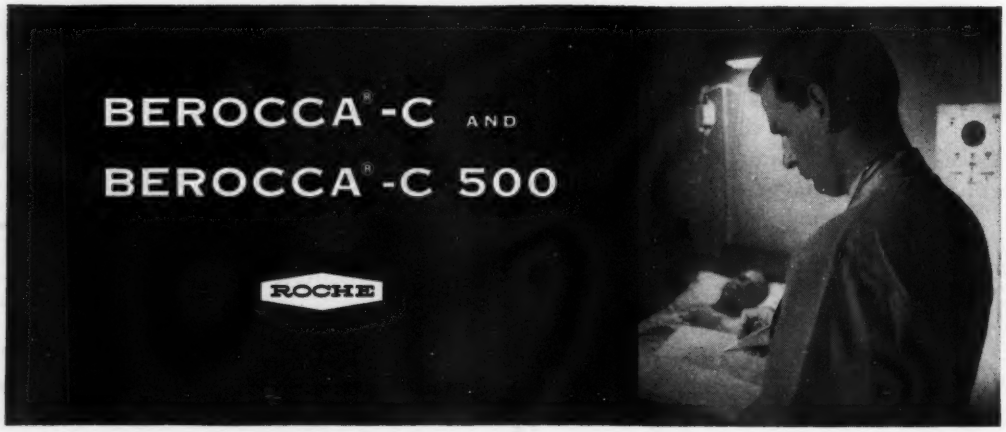

The Hospital Pharmacy Committee in Action

by Robert W. Carithers

Assistant Superintendent
Methodist Hospital
Indianapolis, Indiana

HOSPITALS today are operating in an era when the variety and complexity of drugs and the indications for their use are increasing. The multiplicity of new drugs coming onto the market figuratively each day makes it practically impossible for the practicing doctor of medicine to keep abreast of developments in drug therapy.

Hospital administration and the medical staff are both interested in rational drug therapy as well as efficient pharmacy service.

The hospital today has instituted many checks and balances attempting to make certain that the patient receives the best care possible. The Hospital Pharmacy Committee is coming into its own as an established part of the built-in system of safeguards for the patient.

Hospital Standards

The over-all survey and evaluation of drug usage in the hospital is not a new development. The American College of Surgeons, in developing in 1919 the first set of standards by which to judge the quality of hospital operation, recognized the importance of establishing some means to safeguard the patient from unintelligent and indiscriminate drug therapy. The problem did not become acute, of course, until after World War II when the advances in the development of drugs defied even the most brilliant imaginations. The Joint Commission on Accreditation of Hospitals has recognized the growing problem and, while not specifying it as a requirement for accreditation, considers the Pharmacy Committee a very important educational and advisory tool toward the improvement of patient care in hospitals.

While the Pharmacy Committee is not a definite requirement of the Joint Commission, nevertheless the Commission has felt compelled to assess penalty points on institutions because of the absence of a Pharmacy Committee.

What, then, is the Pharmacy Committee, and what are its specific functions. Sometimes called the Pharmacy and Therapeutics Committee, it is one of the tools for maintaining medical staff self-government. It is a forum out of which develops broad professional policies regarding drug therapy practices, the distribution, use, safety procedures and other matters relating to drugs in the hospital. It is the *liaison between the medical staff and the pharmacy.*

The functions assigned to the Pharmacy Committee are many and varied. They are clearly stated by the Joint Commission and are well covered in current literature. In a broad sense, the Committee is concerned with all aspects of drug usage in the hospital. More specifically, it has been assigned such tasks as the development of a drug formulary, evaluation of the medical record with regard to uses and abuses of drugs, evaluation of clinical data on new drugs or preparations introduced for use in the hospital, review of the pharmacy inventory to eliminate drugs in disuse and to minimize obsolescence, to make recommendations concerning drugs to be stocked on the nursing units and other services, to advise the pharmacist concerning the choice of drugs to be stocked in the pharmacy.

Many other functions and duties can be found which need not be enumerated here. Some are performed by all Pharmacy Committees, but I frankly believe it to be impractical and next to impossible for the committee, as it is established, to do all of these things. The Joint Commission recommends a meeting at least twice yearly; to perform the above tasks alone would require a twice monthly meeting or more.

We have felt in our hospital for many years that the Pharmacy Committee may or may not perform all of the functions attributed to it, depending primarily upon the local situation. The basic organization of the hospital and medical staff, the size and character of the medical staff, the tradition of service and the efficiency in operation of the pharmacy itself all influence and determine the functions of the Pharmacy Committee.

Pharmaceutical Questions

In general, we have followed a policy of taking to the Pharmacy Committee any pharmaceutical question which might have a bearing upon the care of the patient, upon the practice of medicine within the hospital, or which, from experience, we realize should have the full approval of the medical staff before implementation.

When, in recent years, it was deemed advisable that an automatic stop order be instituted on certain dangerous drugs, the question was immediately referred to the Pharmacy Committee for investigation and recommendation. "Dangerous drugs," in this sense, refers to those which might prove habit-forming or injurious to the patient through prolonged or indiscrimnate usage.

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Presented at the Indianapolis Meeting of the American Association for the Advancement of Science, December, 1957.

Responsibilities of the Chief Pharmacist to Hospital Administration

by Robert L. Lantos
Director of Pharmacy Service
University of Texas Medical Branch Hospitals

Part I

■ WHERE DO PHARMACISTS fit into the hospital organizational picture? I can think of no better way to answer this question than by quoting from the late Dr. Malcolm MacEachern who, in his book on *Hospital Organization and Management*, stated,

"In the hospital there are various adjunct facilities used in the diagnosis and treatment of disease, consisting of the x-ray department, clinical laboratory, electrocardiography, physical therapy, pharmacy, and possibly others. These are all part of the hospital organization under the director and each is organized and equipped for its special work. The director is responsible for the selection of the heads of these departments and also for making such contracts as may be authorized. He usually delegates selection of technicians and other personnel to the head of the department.

"The pharmacy is a department in which there will be considerable variation from the general scheme of organization. Goods handled are largely of a nature which make accurate inventory impossible, and buying requires special knowledge. It is, therefore, found to be a good policy for the director to carefully select a capable and trustworthy pharmacist and leave the management of the department to him, except where coordination with other departments is necessary. It is in this department more than in any other that the director delegates responsibility and is less able to check detail of results."[1]

These words coming from such an eminent authority in the field of hospital administration are both complimentary and challenging to our profession. How are you meeting this challenge? If the director is less able to check the results of your department than the other hospital departments, as Dr. MacEachern has indicated, then you have a greater responsibility than do the other departments in interpreting these results for the director.

Administrative Responsibilities of Pharmacist

I would like to discuss your administrative responsibilities as a chief pharmacist at three stages of your career, when you first assume your position, after you have been in the position for some time, and when a new director comes to your hospital.

The first stage begins with your interview for the position. Indicate three general points to the director in the interview: your background and experience are right for the position, you have the kind of personality and intelligence that can make a positive contribution to the hospital, and you are sincerely interested in this type of work.

Understand Organizational Structure

Inquire about the organizational structure of the hospital, the type of patients seen in the hospital both from a medical and financial standpoint, the charge system used by the hospital, the present staff of the pharmacy, the type and volume of activities carried on in the pharmacy, the operating budget of the pharmacy, and the local labor market especially in regard to registered pharmacists.

In a personal sense inquire about your responsibilities, the type of authority which will be delegated to you, your starting salary and the frequency of your increments, and your opportunities of attending professional meetings at the hospital's expense. Then outline more specifically some of your ideas and plans for the pharmacy.

Bearing in mind the four over-all purposes of the hospital, discuss what role the pharmacy will play in these purposes. Emphasize the fact that compounding and dispensing, although an extremely important phase, is but one of many phases of a modern hospital pharmacy. Of course the progressive director already knows this, but he will be waiting to hear you express yourself. Make certain that you will have a sufficient staff, so that you will have time to perform the administrative responsibilities which will be delegated to you and also those responsibilities which you will outline for yourself. I have heard too many pharmacists bemoaning the fact that they have no time to prepare reports for the director; they have no time to work on a formulary; the time which would be involved to undertake a manufacturing program is simply out of the question, and so on. The best time to try to prevent such a situation is before you start. However, if at any time during your career, you encounter a situation such as this; that is you are attempting to give your department the type of administrative attention that it needs, and you have used adequate methods of attempting to convince the director that you need a sufficient staff to enable you to do this; and if there is no affirmative response from the director, then your ability is being partially wasted in this hospital. There are other hospital directors who are looking for your type of a hospital pharmacist. Seek them.

Let us assume that your interview is complete, and it was successful. Now it is time to prove your worth.

Meet Department Heads

Go around and meet the other department heads. Keep a note pad in your pocket and mark down their problems relative to the pharmacy. Ask them what added serv-

Presented at the annual meeting of the Southeastern Hospital Conference, Fontainebleu Hotel, Miami Beach, Florida.

[1]MacEachern, Malcolm T.: Hospital Organization and Management, 2nd ed. Physician's Record Co., Chicago, pp. 95-96. 1957.

[2]Archambault, George, F.: The law of hospital pharmacy, Bull. Am. Soc. Hosp. Pharm. 14:281 (May-June) 1957. ■

ices they would like to receive and relate some of your ideas to them. Meet the members of the medical staff. This may take some time but slowly you will get to know many of them. Make certain of your immediate appointment as secretary of the pharmacy and therapeutics committee. If there is no pharmacy and therapeutics committee, convince the director and the medical staff of its need. Just mention the words, "Joint Commission on the Accreditation of Hospitals," and you won't have any trouble trying to sell this idea. Be an active secretary on this committee and make certain that it is a functioning committee.

Study Your Department

Study closely the procedures which are being used to carry out the various functions in your department. Collect and analyze the many problems which your staff will present to you. You may hear the cry, "We are overworked, we need more personnel." Don't go immediately to the director and ask for more personnel. Perhaps some of the procedures can be simplified, and perhaps a redistribution of the work is necessary. I know of a hospital in which the drug basket filling procedure required five persons three hours to perform every morning. This was a total of 15 man-hours. The drugs were scattered throughout a two-room area and basket filling time looked more like a track meet with people running all over the place. Then the procedure was changed, the area was reconstructed, a prepackaging program was instituted, shelf bottles were installed, and the drugs were concentrated in a smaller area. The new basket filling procedure required only two people two hours to perform or a total of four man-hours. Eleven man-hours were saved by this revision. This allowed the extra man-hours to be redistributed in other areas. It is sometimes difficult for a person who is involved in a particular procedure to realize that certain changes may shorten or improve the procedure. This situation is described by the trite but very meaningful saying, "One cannot see the forest for the trees." It pays to step out of the forest occasionally and do some analyzing.

After you have had ample time to study your department, prepare a written survey for the director including your observations of the present activities of the department and your future proposals. Outline the department into its various functions as well as your newly proposed functions: inpatient dispensary, outpatient dispensary, purchasing and inventory control, manufacturing, educational functions, research functions. Discuss the additional services which the pharmacy will perform for the hospital. Point out the methods for increasing the financial returns of the hospital through your department. Emphasize what your personnel, space, equipment, and other budgetary needs will be in order to carry out your future proposals. Keep your survey on file and after a year or two follow it up with another report discussing which proposals have already been instituted, which are in the development stage, and which have not yet been undertaken with the accompanying reasons.

Robert L. Lantos

Be prepared to comment on surveys which may have been made on your department by an outside source. For example, a number of years ago an independent survey group was hired by our University to do a survey on our hospital. I was not associated with the hospital at the time of the survey, but several months after I had been with the hospital, the survey group came back to find out whether their recommendations had or had not been implemented. The hospital director gave me the list of recommendations pertaining to the pharmacy and asked me to prepare a report stating what had been or was being accomplished that the surveyors recommended, what had not been accomplished and why, and what had been done in lieu of what they recommended. It was interesting to compare this survey with my own survey and to observe with what areas of modern hospital pharmacy practice the group was familiar and with what areas they were not familiar.

The group was aware of the value of such practices as a formulary system, a standard floor stock list, and a narcotic delivery system. The primary aim of a group such as this is to report how financial savings can be facilitated, and the easiest way to show this is by the reduction of personnel. Thus they recommended that the staff be reduced by 33 percent. This would have left the department with a skeleton crew.

For example, it would have allowed for only one pharmacist in the outpatient dispensary in which an average of 350 prescriptions are filled per day. Even with the most efficient prepackaging program such a volume cannot be handled accurately by one person. The group failed to differentiate between the dispensing of drugs and other less vital commodities and, therefore, they failed to recognize the personnel time involved in the control procedures which accompany the manufacturing and dispensing of each drug. Other factors which were not considered in their estimate of the personnel requirements were the prepackaging needs, stock room supervision, educational functions, research functions, and the manufacture of sterile products. In determining methods for financial savings they did not include a manufacturing program. It is a good idea to occasionally have an outside group such as this survey your department. Take an open-minded attitude toward the surveyors and take into consideration the fact that they have had no hospital pharmacy background, if this be the case. If they offer valid recommendations, follow them. If you disagree, take issue with them but be prepared to defend your statements.

State Your Objective

The objectives, policies, procedures, and organization of the hospital in general should also be applied at a departmental level. In order to be evaluated administratively your department should *first* have a statement of objective. This requires only a paragraph or two defining the purpose of your department.

The organization of your department should begin with the Minimum Standard for Pharmacies in Hospitals which states:

"There should be a properly or-

Please turn to page 80

The committee from left to right: Arnold Rivin, Howard Cook, C. J. Foley, Richard Art, and Lynn Wimmer.

Judging

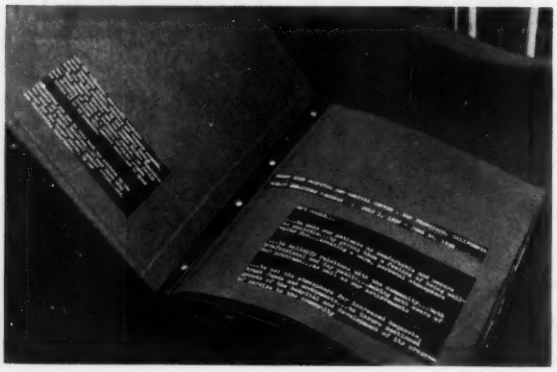
Annual Doctor MacEachern Competitions

■ ON JULY 2, 1958, the following men, prominent in the hospital and allied fields, gathered at HOSPITAL MANAGEMENT to select the winners and runners-up in the annual Doctor Malcolm T. MacEachern competitions. They were chairmanned by C. J. Foley, public relations consultant; Lynn Wimmer, managing editor, *Hospital Administration*, journal of the American College of Hospital Administrators; Howard Cook, executive director, Chicago Hospital Council; Arnold Rivin, editorial director publications for Franklin C. Hollister Company and Richard Art, account executive, Western Advertising Company.

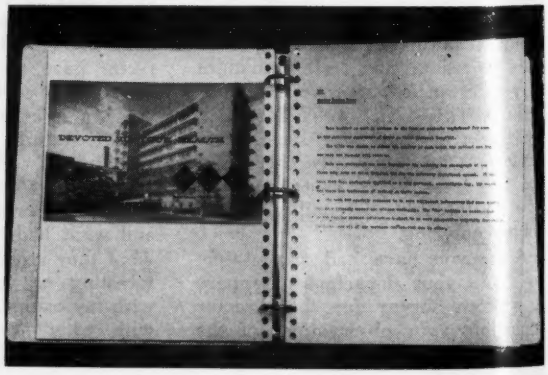
There was a tremendous volume of material to be judged and the committee found it very difficult to decide which hospitals should receive bronze plaques and honorable mentions.

As in past years the contests are governed by a set of rules, which are designed to aid the hospitals' public relations departments in compiling better public relation programs, reports and bulletins. The

The Mount Zion Hospital bronze plaque winner in the public relations competition.



Louis A. Weiss Memorial Hospital's public relations winning entry.



The annual report winners pictured in photo at right are: Decatur and Macon County Hospital, Decatur, Illinois; The Somerset Hospital, Somerville, New Jersey and The Vancouver General Hospital, Vancouver, British Columbia.

rules emphasis the importance of sincerity of purpose and quality of content. These two rules are primarily the guides in the three contests.

The bronze plaque winners in the Public Relations Contest, were excellent in all aspects of telling "their hospital's story" to the patient, community, employees and our committee. The award winners are: Louis A. Weiss Memorial Hospital, Chicago, Illinois, Mr. Mortimer W. Zimmerman, executive director; Mount Zion Hospital, San Francisco, California, Mr. Mark Berke, director; and Miami Valley Hospital, Dayton, Ohio, Frank C. Sutton, M.D., director and Max Elder, director of public relations.

In the Annual Report Competition the Somerset Hospital, Somerville, New Jersey told the story of community service in their annual audit entitled, "Your Hospital and Timmy's". The administrator of Somerset Hospital is Nelson O. Lindley and Mrs. Sylvia Papier is director of public relations.

The Decatur and Macon County Hospital Association, Decatur, Illinois, set forth in their audit some of the work which the community does for the hospital, which includes supplies and help of all kinds from those who furnish talent, time, effort and money. The administrator is Leon Pullen, Jr. and the public relations director is Mrs. Virginia R. Mickel.

The Vancouver General Hospital's annual report reviewed each department and its operations. The director of this hospital is L. N. Hickernell.

Scripps Memorial Hospital in La Jolla, California, won again for their excellent community bulletin, "The Surf Line". The administrator is G. C. Crary.

The Orange Memorial Hospital, Orlando, Florida, entry the "Orange Memorial Express" is for the purpose of information, education and improved employee morale. The administrator is Arthur L. Bailey and James T. Hopkins is public relations director.

Western Pennsylvania Hospital, Pittsburgh, Pennsylvania is also a winner again with the entry "West Pennings". This bulletin is published for the purpose of acquainting the hospital employees of the activities of each department and the activity of the hospital as a whole in community service. A concurrent purpose is to present an inside story to patients and community leaders. ■

Hospital Bulletin bronze plaque winners in photo are: "West Pennings", entry of Western Pennsylvania Hospital, Pittsburgh, Pennsylvania; "Orange Memorial Express", from The Orange Memorial Hospital, Orlando, Florida; and "The Surf Line", entry of Scripps Memorial Hospital, La Jolla, California.

Pharmacy Inventory Problems in Hospital Financial Management

by Arthur J. Sallee

Comptroller
Lincoln General Hospital
Lincoln, Nebraska

Editor's Note: Here is a fine article on the importance of pharmacy inventory written to administrators and hospital pharmacists by a hospital accountant. Mr. Sallee is well qualified in that he has been a hospital comptroller for a number of years. Prior to joining the hospital world he spent two years with a well-known certified public accounting firm. Mr. Sallee is a graduate of the University of Nebraska and is deeply interested in hospital accounting. He understands the problems of hospital pharmacy inventory, expense and income. He feels as I do that comptrollers (business managers) and pharmacists must work closely together all the time to insure efficient financial output of pharmacy departments in all hospitals.

I am sure every administrator and hospital pharmacist will find these views of a hospital accountant very worthwhile.

D. F. M.

Arthur J. Sallee

■ ADMINISTRATORS AND COMPTROLLERS of every hospital have a strong responsibility of financial balance. The income, regardless of its nature, must equal or exceed costs. Income can come from money and varied sources including revenue from services, gifts, endowments and bequests. Costs likewise penetrate from several areas including salaries, supplies, repairs, depreciation, doubtful accounts and many others. But regardless of the multitude of sources, income must equal or exceed costs in hospitals the same as in any successful business. No economic unit, including hospitals, can exist for long when the outgoing funds are greater than incoming funds.

What can the hospital pharmacist do in assisting management in maintaining a favorable financial balance?

The pharmacist should realize his influence in the area of hospital financial management. The pharmacy department is among the largest income producers within the "revenue from patient service" groups. In most instances the pharmacy will create a dollar net revenue with the least direct cost. (This can be computed by dividing departmental direct cost by departmental net income and comparing with other revenue departments).

As hospitals become more dependent upon the income from patient service, the influence of the pharmacist in financial management will become more important. Consequently the pharmacist should have a thorough knowledge of good business practice and comprehend records of account. One of the most important tasks a pharmacist must master in the field of financial management is the problems concerned with inventories. There are two particulars that are most difficult, one of definition and the other of valuation.

What Is Included in Inventory

For purposes of definition, when we speak of "inventory" we should include only those items in stock which we own and hold for resale. Therefore, we immediately exclude items such as office supplies, bottles, boxes, labels. Such items are not inventory but prepaid expenses. As to ownership, we must determine if title has passed. Items which have been ordered but not received may belong in the inventory. A good rule to follow is, if the drugs were shipped F.O.B. shipping point, they belong to the purchaser; if they were shipped F.O.B. destination and have not arrived at the destination, they belong to the seller. The two most common errors caused by not including all goods owned in the inventory are:

1) The invoice may be recorded by the bookkeeper and excluded from inventory by the pharmacist—this results in an overstatement of costs.

2) The invoice and the item both excluded from inventory results in inaccurate showing of purchases and inventory in the income statement and balance sheet.

The problem of inventory valuation will remain with us as long as business continues to grow and prices continue to change. New theories will develop and replace the old as long as our economy resists being static. At the present time there are three methods of valuation commonly used by hospitals:

1) Cost or market, whichever is lower.
2) Average cost method.
3) Last invoice price.

Cost or Market, Whichever Is Lower

This method is one which is used by the conservative accountants; it anticipates no profit and provides for all possible inventory losses. This is obvious when it is understood that the cost represents what the pharmacy paid for an item compared to what the pharmacy would pay at valuation date and selecting the lowest of these figures.

There are three ways of applying the cost or market method:

1) Comparing the cost and market for each individual item and valuing the inventory at the lower figure by items.

2) Comparing the total cost and market of similar categories selecting the lower figure.

3) Comparing the total cost and market for the entire inventory and using the lower figure.

Average Cost Method

This method is used in small hospitals which maintain perpetual inventory records and only a sample of physical counting is done to determine inventory record accuracy. Usually this method is used as an internal check and may not be ac-

ceptable for audit and certification purposes.

It is computed in the following manner: determine the number of purchases made and divide this into the sum of the unit price. Example:

1) Five purchases of an item.
2) Unit price of each purchase was $1.00, $1.95, $2.00 and $2.10.
3) There were 10 items in inventory

$$\frac{1.00 + 1.95 + 2.00 + 2.10}{5} \times 10$$

$$\$1.41 \times 10 = \$14.10$$

This valuation for each item is $1.41 and total valuation for the quantity is $14.10.

This method is widely used in small hospitals with limited inventories but is not recommended because the large and small purchases are given the same weight.

Last Invoice Price

The last price paid for a unit is the price applied to all the inventory quantity of this unit. In the example given previously the unit price of $2.10 would be applied to all five units, giving a total valuation of $21.00.

This method is satisfactory if there is sufficient inventory turnover to assure that price fluctuations would be immaterial and some assurance that items are sold somewhat in the same order in which they are purchased.

All pharmacists should be concerned with their costs. Their costs, in part, are determined by the method in which the inventory is valued. As an example, let's assume the following purchases were made:

1) 5 items at $3.00
2) 10 items at $3.05
3) 4 items at $2.95

Further, let's assume that the market or current price at inventory date was $3.06.

If all of these items were on hand at closing, the valuation or cost would be as follows under the three methods:

Cost or market, whichever is lower—

	Cost	*Market*
5 × 3.00	$15.00	$15.30
10 × 3.05	30.50	30.60
4 × 2.95	11.80	12.24
	$57.30	$58.14

Average method—

$$\frac{3.00 + 3.05 + 2.95}{3} \times 19$$

$$\frac{\$9.00}{3} \times 19$$

$$\$3.00 \times 19 = \$57.00$$

Last invoice price—

$$\$2.95 \times 19 = \$56.05$$

The valuation range is from $56.05 to $57.30, and consequently each method would reflect a different cost figure and, depending upon which method was used, would either decrease or increase pharmacy departmental net income. The examples used are intentionally extreme in order to point out that the pharmacist should be familiar with inventory valuation and their effect on financial operations. Such variation may not exist in any one quantity but with the large number of items and quantities in the pharmacy the net result may be material.

In order to prevent wide fluctuations in inventories due to valuation method, the hospital management must insist on a given plan and be consistant with this method every year.

Regardless of the method used for inventory valuation, items which have become obsolete should be excluded from the inventory. If it can be sold at a reduced price, the realizable value should be placed on it. The loss on goods should be taken in the year the loss was incurred or discovered.

Inventory is the problem which constantly faces the pharmacist. In his hand is the power to create income or incur undue costs. He should become thoroughly familiar with all the problems of inventory in order that he can fulfill his role in the scheme of hospital financial affairs. ■

The Modern Hospital Pharmacist

by Daniel F. Moravec
Pharmacy Editor
Hospital Management

■ THE MODERN HOSPITAL PHARMACIST is strictly a professional person. His practice of pharmacy is a continual process, even more so than other branches of pharmacy.

The modern hospital pharmacist must be able to dispense drugs as must the retail pharmacist, but he is also more closely associated with the members of the medical staff. In this respect the hospital pharmacist is a full-fledged member of the hospital health team. In any hospital the main objective is to help the sick get well, and the hospital pharmacist serves as a valuable consultant to the medical and nursing staff in all matters relating to pharmaceuticals. In a lesser degree the retail pharmacist is a consultant too, but his time is divided into many diversified things. The demand on the retail pharmacist for consultation is not the constant everyday thing that it is in the case of the hospital pharmacist where opinions concerning drugs are one of his main charges. The hospital pharmacist does not have to divide his thinking in non-drug activities such as merchandising, or commodities other than pharmaceuticals, or in stiff product competition or the like.

The modern hospital health team is composed of specialized professional people such as the radiologist, the pathologist, the hematologist, urologist, obstetrition and many others, plus the hospital pharmacist who is the specialist in chemical therapeutics.

For example, the hospital pharmacist is the drug specialist member on the hospital's pharmacy and therapeutics committee which is the sub-division of the medical staff which passes on drugs to be used in the hospital. The hospital pharmacist may also be the chemical specialist on research committees of the medical staff. In times of kidney blockage where life and death may hang in balance, it may be the hospital pharmacist who prepares the sterile chemical solutions with which the surgeon may flood an abdomen. This may preserve life in patients with renal blockage until nature can heal the kidney and allow it to function again.

Hospital pharmacy is that subdivision of pharmacy which concerns itself with the medicinal agents used to treat patients in hospitals and through which all concerning drugs and chemicals in the hospital are channeled. As head of the hospital pharmacy, the hospital pharmacist works constantly in close

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A Continuing Responsibility . . .

PREVENTING

by Charles U. Letourneau M.D. ***Part II***

Oxygen Administration

When oxygen administration is begun in the delivery or operating room, the infant should be transferred to the nursery quickly, with enough attendants to insure proper observation of the infant and continuation of the oxygen flow. The premature nursery should be notified in advance of such a transfer so that preparations can be made to continue oxygen administration efficiently.

Incubators. There are several different incubators on the market. Each varies in some detail of operation. The nurse must study carefully the operating instructions provided by the manufacturer of the apparatus. In general, the points to remember for safe administration of oxygen by incubator are:

1. Be sure that the flowmeter or regulator is attached in an upright position and in such a way that the gauges are within easy view of nursery personnel. Readings might be inaccurate if the flow-indicator tube is tilted. If an oxygen cylinder is used, place it in a cylinder stand so that it cannot be knocked over.

2. When therapy is started, set the flow at the rate recommended by the manufacturer. Every five minutes, test the percentage of oxygen within the incubator with an analyzer (*figure 1*) and adjust the flow until the concentration has stabilized at the desired level. Recheck the concentration at least every four hours and record the results on the patient's chart. Frequent analyses are necessary even when oxygen limiting devices are attached to incubators.

3. Periodically check the apparatus to see that nothing interferes with oxygen flow. See that all connections are secure and that there are no kinks in the tubing. Clear out any dust that has accumulated on the air intake filter. Each incubator should have a built-in analyzer connection to give greater efficiency.

Analyzers. It is important that the nurse read carefully the manufacturer's instructions for using the analyzer. Each of the several types available varies in some aspect of operation. However, they do have several points in common that should be stressed.

When an analysis of the incubator atmosphere is made, insert the sampling tube so that its end is near the infant's nose and mouth. Never put the analyzer itself inside the incubator; the electrical switch could cause a spark. Squeeze the hand bulb the number of times indicated in the manufacturer's directions. It is important to flush the analyzer thoroughly to drive out room air and fill it with the atmosphere from within the incubator. Press the button and hold it down until the indicator stops moving. The results of each analysis, along with the time it was made, must be entered on the patient's chart.

One analyzer should be assigned exclusively to the nursery. A second analyzer should be used in other parts of the hospital.

Humidity. Oxygen has a drying effect on the mucous membranes. Therefore, it is customary to add a water suspension to the oxygen stream to supply supplemental moisture to the respiratory passages. Most incubators are equipped with a water reservoir to provide a moistened atmosphere. When high humidity is needed, a humidifier can be attached to the oxygen intake line. Humidifiers can also be used to administer wetting agents or aerosolized drugs.

Limiting Oxygen Concentrations. "Oxygen concentration should be kept at the lowest possible level that will relieve the symptoms for which it is given, if possible, not over 40 percent."[1]

Several methods can be used to limit the concentration of oxygen to the prescribed percentage.

1. Oxygen flow can be gradually adjusted until repeated analyses show that the desired concentration is being delivered.

2. A mixture of 40 percent oxygen and 60 percent nitrogen can be delivered to the incubator. When a cylinder of this mixture is used, the infant can receive no more than 40 percent oxygen.

3. An oxygen diluting meter can be attached to the incubator. This device, which mixes room air with pure oxygen, can be set to deliver a 40 percent concentration or higher if desired. Although such equipment is an additional safeguard, it is a mechanical device and is subject to breakdown or misuse. It is not a substitute for an oxygen

Fig. 1. Frequent analysis is the only sure way to control oxygen concentration delivered to infants in incubators.

Part I is on page 47 of the August issue of Hospital Management.

analyzer. Analyses must still be made to see that the desired oxygen concentration is being obtained.

Charting. Adequate records of all oxygen administered must be kept to show pertinent details of the treatment, correlation between the prescription and actual administration, and the clinical effect of the treatment, and to provide information for billing. Each infant's chart should contain a separate Oxygen Therapy Case Record (*figure 2*). This record should have space for charting these essentials:

1. The physician's written order. This should include method of administration, oxygen concentration, and time duration.
2. Time of onset and termination of therapy, including all interruptions. Details of therapy should be charted every four to eight hours.
3. Oxygen concentrations as determined by analyses at least every four hours.
4. Physical and emotional response of the patient, such as: color, type and rate of respiration, pulse, degree of restlessness or lethargy.

Care of Equipment

Regular servicing and overhauling of oxygen therapy equipment is necessary to guarantee safe and effective therapy. Hospital personnel should be able to judge the effectiveness of the equipment and know what to do when it is out of order. Each hospital should have available a qualified inhalation therapist on a full-time or part-time basis. Membership in the American Association of Inhalation Therapists is some evidence of qualification.

Care of Incubators. Incubators should be adequately disinfected with a detergent-disinfectant solution after each use.

Incubators need periodic servicing. The manufacturer's instruction manual gives details of care for the individual incubator. When repairs are necessary, they can be done by the oxygen therapy technician, the maintenance department or the manufacturer.

Care of Analyzers. All analyzers have a silica gel container through which the sample of atmosphere from the administering apparatus passes before it enters the analyzing chamber. In some analyzers ("O.E.-M.", "Beckman") the sample must be dry for accurate readings and, in this case, the silica gel serves as a drying agent. In others ("Mira") the sample must contain a specific amount of moisture for good results. In this case, the silica gel used is damp. It gives up water to samples that are too dry and absorbs it from samples that are too moist. When silica gel crystals are dry, they are blue, and when they are moist, they are pink. Be sure you know which type of crystal is needed for your analyzer.

When silica gel crystals that are used for drying absorb too much moisture, they turn pink. If this happens, remove the container from the analyzer and drive off the excess moisture by exposing the crystals to a source of dry heat until they regain their blue color. If the blue color does not return, fill the container with fresh crystals.

When silica gel crystals that should be damp turn blue, remove the container and pour the contents on a flat dish exposed to the atmosphere. Allow them to stand for several hours until the pink color is restored. These moist crystals retain their activity longer than those used for drying.

When the proper color does not return, the crystals must be replaced with a fresh supply. Put fresh cotton packing in the ends of the vial each time it is refilled with reactivated or new crystals.

Test the accuracy of the analyzer daily by drawing in a sample of pure oxygen and taking a reading. The indicator should register 100 percent. If the analyzer gives an inaccurate reading, check the battery and replace it, if necessary. Occasionally the light bulb in a "Beckman" analyzer needs replacement. Periodically check the tubing, the caps for the silica gel vial, the vial itself, and the hand bulb for leaks. If a worn hand bulb must be replaced, be sure that the proper type is used. It must have a hole at the end through which residual oxygen from the sampling tube can escape as the bulb is squeezed.

Review of Practices

By comparing the present practice of oxygen administration to

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Order: 7/29 Start oxygen by incubator at 36%. Name Baby Smith

Reg. No. 67508

Physician: J. B. Jones, M.D.

Date	O_2 Concentration (by analysis) Time	%	Analyzed by (Initials)	Liter Flow	Interruptions to Therapy	Duration of Therapy (Total the specific number of hours oxygen is administered during each 24-hour period.)
7/29	12:15 am	27%	NEC	1		
7/29	12:30 am	33%	NEC	2		
7/29	1:00 AM	36%	NEC	3		
7/29	5:00 AM	36%	NEC	3		
7/29	9:00 am	36%	NEC	3	10:05 AM out of O_2 for examination.	
7/29	—	—	—	3	10:20 AM back in O_2. SDN.	
7/29	10:25 am	32%	SDN	3		
7/29	10:45 am	36%	SDN	3		
7/29	11:00 am	36%	GD	3		
7/29	3:00 pm	36%	LBC	3		
7/29	7:00 PM	36%	LBC	3		
7/29	11:00 AM	36%	NB	3		23 hrs. 30 mins.
7/30	3:00 AM	36%	NEC	3		
7/30	7:00 AM	36%	NEC	3		
7/30	11:00 AM	36%	NEC	3		
7/30	—	—	—	—	11:45 am. O_2.	Discontinued SDN 11 hrs. 45 mins.

PREMATURE NURSERY
OXYGEN THERAPY CASE RECORD

Fig. 2. Sample Oxygen Therapy Chart for premature infants.

Henry L. Verhulst

by Henry L. Verhulst

The Pharmacist and the

■ In 1956, 1350 people died from the accidental ingestion of poisonous materials. Of this number 370 or 27 percent were children under five years of age. It is significant that these children, who suffer more than one-fourth of our poisoning deaths, constitute only about one-tenth of our population.

As technological advances in the fields of science have led to a tremendous decrease in mortality of the infant from infectious diseases by producing vaccines, antibiotics and chemotherapeutic agents, they have at the same time increased the potential threat of poisonings by producing numbers of toxic substances such as insecticides, solvents, and detergents which are commonly used in the home. You may be interested to know that a minimum of 250,000 brand name chemical products are now on the market and the number is increasing daily.

To combat this ever increasing threat to all householders, and the toddler in particular, a number of health authorities set about to devise a plan of action. Under the auspices of the Illinois Chapter of the American Academy of Pediatrics, a pilot project was initiated in Chicago to attempt to find the best methods of combating such poisonings. The project was established as a poison control center, involving the cooperation of the heads of the pediatric services in the major hospitals, the Health Department, State Toxicological Laboratory, and other State and local authorities. The program drew together into a working unit some 20 hospitals, four full-time health departments, five medical colleges, the local medical society, the local chapter of the American Academy of Pediatrics, and other groups.

Poison Control Centers

When the Chicago Center opened in November 1953, information, treatment, and prevention of accidents were its major objectives, and procedures were developed to achieve these goals. Dr. Edward Press was chairman of the Chicago Center at this time. Through his guidance, and with the support of the American Academy of Pediatrics and its Accident Prevention Committee, similar centers were established throughout the country.

Following the Chicago plan, poison control centers have been established in many other cities. The organizational patterns of the various units depend upon the facilities available to the group wishing to establish the center. Some centers utilize their city health department as the major focal point (New York). This has its advantages, for the department usually has facilities for reporting, analyzing and summarizing the case from participating hospitals. The department personnel may be used also to make any necessary follow-up home visits needed to obtain more complete epidemiological data on the poisoning cases and to give information which might aid in prevention of future cases.

Some centers are situated in the major children's hospital or the university pediatric department in their respective communities. In these instances the chief pediatric resident frequently acts as executive director, with the pediatric residents answering calls on poisoning. Others are situated in the emergency room of a local hospital. Here, frequently, a member of the local pediatric society acts as executive director. The emergency room nurse may take calls in this case, but then refers these inquiries to competent medical authorities who are on continuous call.

The number of poison control centers is increasing rapidly. Soon after the first few were established it became apparent that a focal point for the dissemination of material and case reports among the various centers was desirable. On November 12, 1956, the Subcommittee on Chemical Poisons of the Committee on Research and Standards of the American Public Health Association met with a group of representatives of National Agencies and Poison Control Centers to discuss the establishment of a National Clearinghouse. This committee accepted the suggested blueprint of the Steering Committee for the formation of a National Center and further recommended that the U.S. Department of Health, Education, and Welfare be approached in regard to carrying out the proposal. On February 26, following subsequent meetings, the National Clearinghouse for Poison Control Centers was officially established in the Public Health Service, Bureau of State Services, and assigned to the Accident Prevention Program of the Division of Special Health Services.

National Clearinghouse

The National Clearinghouse was established, then, as a service organization to aid and abet the poison control centers in decreasing the number of accidental poisonings by an active program of treatment and prevention.

In order to treat a poisoning case it is necessary, first, to be able to identify the substance ingested and, secondly, to have adequate knowl-

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Presented to the American Association for the Advancement of Science (Pharmacy Section) at Indianapolis, December, 1957.

Local Poison Control Center

edge concerning the toxicity of the substance and its pharmacological actions. The National Clearinghouse plans, through an active campaign, to contact manufacturing units for information on all formulations of household items which they market. It is hoped that once the functions of the Clearinghouse become well known, many producers will automatically forward the necessary information to us. The reports from local poison control centers, showing items ingested, should be another valuable source of information on new products, particularly those marketed in local areas.

The problem of finding the actions of some of the chemicals used in some formulations may be a formidable one. The Food and Drug Administration requires complete studies on drugs. The Federal Insecticide, Fungicide and Rodenticide Act of 1947, administered by the Department of Agriculture, likewise requires that adequate toxicity studies be made of all new chemicals used in these products. Adequate information about other substances is often difficult to find, if not unobtainable. In some instances a thorough review of literature may produce it; however, cases arise where adequate studies have not been made or where, if they have, the results are locked in the files of the producer. It is almost impossible to find toxicity studies on formulations *per se*. In most cases these can only be conjectured from the knowledge of the active ingredients. Perhaps a study of case reports may prove enlightening on some of these products.

The Clearinghouse plans to disseminate information it obtains regarding products on 5 by 8 file cards. These will show the trade name of the preparation, type of product, manufacturer, ingredients if furnished, toxicity of substances, any signs and symptoms which develop, and treatment. After establishment of a basic file, we plan to furnish supplemental cards every month on new items being reported and changes in old formulations.

We hope to stimulate research in the development of new methods of prevention and treatment of poisoning cases. When reviewing the various treatments of some of the more common items ingested, it is not uncommon to find tremendous differences of opinion existing concerning proper treatment. There is need for increased basic and clinical research.

The National Clearinghouse, in conjunction with the American Public Health Association, has developed a proposed standard poison reporting form, copies of which have been distributed to the centers. When returned to the National Clearinghouse these will be coded and tabulated. Such data, it is felt, will yield information which can be of definite value in planning successful methods of treatment and prevention. Prevention, not treatment, would be the most suitable solution to the problem of poisoning. This can best be achieved through effective education of the lay population.

Role of the Pharmacist

The pharmacist can well assume an important role in this program aimed at decreasing deaths from accidental poisoning. Both by professional training and experience he is well qualified to review scientific literature and excerpt those articles pertaining to symptoms and treatment of chemical intoxication. During his normal business activities he receives a number of journals and a large amount of technical literature which contain information on brand name products both new and old. He has contact with a large number of representatives from various industries in addition to the drug industry. From these sources he can obtain immediate information on new products being marketed in his area.

The director of the local poison control center in your area would appreciate receiving information you obtain on new products. Why not call on him in the near future and offer your services? Discuss the type of file he keeps and the form in which he records his material. It is probable that you can supply him with information in a form which may be filed without retyping.

In practically every community in the Nation, the pharmacist holds a position of high prestige as a member of his community's health profession. It frequently happens, therefore, that he is the first person called in the case of accidental poisoning. The pharmacist should have information about local facilities to which the person making the inquiry may be referred for immediate treatment, should it be necessary.

Treatment is, of course, the responsibility of the physician. Successful treatment is, however, usually dependent upon team work. The pharmacist should familiarize himself with the newer antidotes which are available, even if only on an experimental basis, so that he will have a knowledge of the sources of supply of such drugs if needed. Reports are continually being received on the use of hemodialysis or exchange blood transfusions in some types of poisonings, particularly barbiturates, salicylates and mercurial salts. We should all familiarize ourselves with such procedures and the drugs required in their use.

No group is closer to the basic

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You Can Provide 24-Hour Pharmacy Service

by William E. Hassan, Jr., Ph.D.

■ BECAUSE of the improved economic standard of living for the average family and the intense health education programs sponsored or conducted by the various agencies and associations, hospitalization has been steadily increasing during the past decade.

Paralleling the increased census is the demand for service placed upon the hospital's professional personnel including pharmacy.

Sickness and pain do not keep office hours. They strike when least expected. It is essential, therefore, that medical service be provided 24 hours per day everyday. Hospitals today meet this requirement by providing 24-hour medical and nursing service, laboratory, x-ray, blood bank, and emergency surgical services. Each of the above services is provided by specialists in the field and in compliance with all of the governing laws as well as the provisions of the accrediting organizations.

The one service which has been provided on a make-shift basis has been the pharmaceutical service. Hospital administrators should review their present pharmacy service and immediately institute one which will provide them with the peace of mind associated with the knowledge that they have provided adequate, legal pharmacy service during the "off-hours."

Most small hospitals operate the pharmacy eight hours per day for a total of 40 hours per week. This means that pharmaceutical service must be provided for 128 "off-hours" — nearly three times the normal pharmacy hours.

Larger hospitals, having more than one staff pharmacist, operate the pharmacy ten hours per day for a total of 70 hours per week. Pharmaceutical service must still be improvised for 98 "off-hours."

The professional literature is replete with the various methods employed by hospitals, both large and small, to cope with the problem. The following is a brief outline of the methods employed:

1. Allow the *night supervisor* to enter the pharmacy and provide a restricted pharmaceutical coverage.
2. Provide a *night emergency box* and a *night drug supply cabinet*.
3. Close the pharmacy to all members of the nursing staff. If the drug needed is not in the emergency cabinet or on the nursing station, allow the prescribing physician to enter the pharmacy and dispense the necessary item.
4. Institute an "on-call" program for the hospitals' staff pharmacist.
5. Institute a program whereby a retail pharmacy provides emergency service.
6. Review the supply of pharmaceuticals currently available on the nursing station and re-stock it in the light of the demand of current therapy.

Use of Night Supervisor

The use of the night supervisor to provide after hour service is viewed by many administrators as

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Appreciation is expressed to West Penn Hospital, Pittsburgh 24, Pennsylvania, for the use of the illustration.

an acceptable practice. It is their argument that if the nurse is capable of selecting and administering a medication from the medicine closet then she should be and is perfectly capable of doing the same from the pharmacy.

This is not wholly true. Medications which are sent to the nursing station or to the emergency cabinet are especially labeled for the convenience of the nurse. Any special packaging or handling has usually been exercised by an individual educationally competent and legally qualified to perform the task.

The selection of a medication from the medicine cabinet does not offer the degree of confusion which might be expected when the nurse views shelves lined with hundreds of containers of tablets and capsules. It is obvious that the fewer the units to select from the lower the possibility of the incidence of error.

The graduate nurse entering the pharmacy after hours should not in any way attempt to compound a preparation. This facet of dispensing pharmacy is especially reserved for the licensed practitioner of the profession.

With the current nurse shortage, administrators should make every effort to conserve nursing time and personnel for actual patient care.

Use of Emergency Box

Of late, there has been widespread publication of ways and means of preparing *emergency boxes* and *night drug supply cabinets* for after pharmacy hours use of the medical and nursing staff. Some of the cabinets are relatively simple while others are relatively complex and expensive.

The simple ones have utilized special containers placed on the nursing station and contain a meager supply of drugs. The more expensive units have been constructed to include a refrigerated section and contains a package of nearly every item stocked in the pharmacy.

Obviously neither of the above described units is desirable. One is too simple and may not make available the urgently needed item; the other is so elaborate and large that, in all probability, it must be located away from the patient pavilions and it makes available too large a variety of drugs thereby introducing the risk of error.

A unit available near the patient pavilion and containing a therapeutically selected group of drugs (the selection being done by the staff through the Pharmacy Committee) is the safest and the least costly.

An *emergency box* is necessary to expedite treatment in certain emergency situations. The drugs usually needed are oftentimes not readily available on the ward and the time taken to secure them from the pharmacy, day or night, might seriously hinder the treatment of the patient.

At the Peter Bent Brigham Hospital certain drugs and supplies are kept on all of the wards. The drugs and smaller items are kept in a white enamel metal box marked "STAT." This box is kept on the treatment table ready for use at all times. A typed list of the contents is affixed to the inside of the hinged cover. The larger items of supply are kept in the ward cabinet or utility room and clearly labeled and marked "Emergency Use Only."

The drugs are charged to the patient by the nurse after use of the "stat box." Upon presentation of the charge slip to the pharmacy, the expended supplies are replaced in the box.

Use of Night Drug Supply Cabinet

A *night drug supply cabinet* is provided for the purpose of making available to the resident medical staff a supply of drugs and diagnostic agents in order that they may pursue therapeutic and diagnostic procedures on late patient admissions.

At the Peter Bent Brigham Hospital a 20-drawer steel cabinet with locking doors constitutes the night drug supply cabinet. The drawers on the left are numbered from 1 to 10. The contents of each drawer are listed and affixed to the inside of the cabinet door, similarly the drawers on the right hand side are numbered from 11 to 20 and their contents listed and affixed to the inside of the cabinet door.

The unit is locked and is kept in the nursing office. The keys are on the key ring of the night supervisor.

Upon withdrawing an item from the cabinet, the supervisor prepares a charge ticket in the name of the recipient patient and deposits same in the box provided for such charges on top of the unit.

The following morning, the charges are collected by a member of the pharmacy staff and the drug supply restored to original volume.

The decision to close the pharmacy to nursing personnel and allow a physician to enter the pharmacy and obtain special medication not found in the emergency cabinets appears to be a safe administrative and legal practice.

The major drawback to such a system is that it places the inconvenience upon the physician. In these days of shortages of physicians this is not a fair burden to place upon the shoulders of this particular group.

The one advantage which such a system may have is that it will encourage the physician to make use,

Drugs and Supplies for "Stat" Box

Ampuls of:
- Aminophylline
- Amphetamine sulfate
- Atropine sulfate
- Caffeine sodium benzoate
- Calcium gluconate
- Digoxin
- Epinephrine
- Heparin
- Hydrocortisone acetate
- Magnesium sulfate
- Nalorphine*

Amyl nitrite inhalation

- Alcohol sponges
- Ampul files
- Cardiac needle
- Clamps
- Mouth piece
- Razor
- Sterile pads 2 x 2
- Tourniquet

Neostigmine bromide
- Norepinephrine
- Pentobarbital sodium
- Pentylenetetrazol
- Phenobarbital sodium
- Phenylephrine HCl
- Picrotoxin
- Procaine amide
- Protamine sulfate
- Protoveratrine A & B
- Saline 50 cc.
- Sodium hydantoin
- Vitamin K oxide

Syringes
- 4 — 2cc.
- 4 — 5cc.
- 1 — 20cc.

Needles
- 2 — No. 18
- 2 — No. 20
- 2 — No. 23

Supplies for Ward Cabinet or Utility Room
- 1 Venous intubation set
- 1 Venous cannulization set
- 3 Phlebotomy kits

*NARCOTIC—Accounted for as any other Floor Stock Narcotic.

Approved products stored in the night drug supply cabinet

AMPULES*

Drawer 1
- Achromycin I.M. 100 mg.
- Achromycin I.V. 500 mg.
- A.C.T.H. 25 units
- A.C.T.H. gel 40 units
- Adrenalin
- Adrenalin, topical
- Adrenosem
- Amytal sodium 0.25 Gm.
- Ansolysen 10 mg/cc 10 cc.
- Aureomycin I.V.

Drawer 2
- Bacitracin I.M.
- Bendaryl 10 mg/cc 10 cc.
- Berocca C
- B.S.P.
- Calcium chloride
- Calcium gluconate
- Chloromycetin I.M.
- Chloromycetin I.V.

Drawer 3
- Chlor-trimeton 100 mg/cc.
- Congo red
- Coramine 1.5 cc.
- Cortisone acetate I.M.
- Depo-testosterone 10 cc.
- Digitoxin
- Digoxin
- Dilantin
- DOCA (percorten-TMA) 4 cc.
- DOCA-TMA (percorten-TMA) 4 cc.
- Ephedrine I.M.
- Erythromycin 300 mg.
- Erythromycin 1 Gm.

Drawer 4
- Gantrisin
- Heparin liquaemin 1000 units
- Heparin sodium
- Hydrocortisone I.V.
- Hykinone 5 mg.
- Hykinone 72 mg.
- Isuprel I.V.
- Isuprel inhalation (c medihaler)
- K_1 oxide, vitamin (mephyton)

Drawer 5
- Levophed
- Magnesium sulfate 25%
- Magnesium sulfate 50%
- Mercuhydrin 2 cc.
- Nembutal 250 mg.
- Neomycin 0.5 Gm.
- Neosynephrine 5 cc.
- Nicotinamide
- Nitrogen mustard (mustargen)

Drawer 6
- Penicillin-G 1 million units
- Penicillin-G 5 million units
- Penicillin S.R.
- Penstrep 4:½
- Phenergan 25 mg. 1 cc.
- Pitressin tannate in oil 1 cc.
- Polymyxin — B
- Premarin I.V. 5 cc.
- Probanthine
- Prostigmin 0.5 mg.
- Protoveratrine (veralba)
- P.S.P.

Drawer 7
- Quinidine HCl 0.18 Gm.
- Quinidine gluconate 10 cc.
- Scopolamine 0.65 mg.
- Serpasil 2.5 mg/cc.
- Sodium glutamate
- Sodium iodide 1 Gm.
- Sodium lactate
- Sodium salicylate 1 Gm.
- Sparine 2 cc. 50 mg/cc.

Drawer 8
- Streptomycin 1.0 Gm.
- Terramycin I.M. 100 mg.
- Terramycin I.V. 500 mg.
- Thiamine HCl 10 cc. 100 mg/cc.
- Thorazine 25 mg.
- Thytropar 10 U.S.P. units
- Urecholine 5 mg.
- Wyamine 10 cc.

Drawer 9
- Sodium Bicarbonate

Drawer 10
- Empty

ORAL PREPARATIONS

Drawer 11
- Achromycin
- Bendadryl 25 mg.
- Benemid 0.5 Gm.
- B_{12} vitamin
- Chloral hydrate
- Chloromycetin

Drawer 12
- Cortisone 25 mg.
- Diamox 250 mg.
- Dicoumarol 25 mg.
- Donnatol
- Equanil 500 mg.

Drawer 13
- Erythromycin 250 mg.
- Furadantin 100 mg.
- Ferrous gluconate
- Ferascorb
- Gantrisin
- Gelusil
- Isoniazid

Drawer 14
- Isuprel
- Luasmin
- Mandelamine 0.5 Gm.
- Meticorten 5 mg.
- Neomycin 0.5 Gm.
- Penicillin-V 400,000 units

Drawer 15
- Probanthine 15 mg.
- Serpasil 0.25 mg.
- Telepaque
- Thorazine 25 mg.

Drawer 16
- Sparine 25 mg.
- Triple Sulfa
- Valmid 0.5 Gm.

Drawer 17
- Empty

Drawer 18
- Ace bandage 3 inch
- Aminophyllin suppositories
- Bacitracin ointment
- Benylin expectorant 2 oz.
- X-prep

Drawer 19
- Fleet enema
- Foley catheter No. 16 c 5cc. bag
- Foley catheter No. 14 c 5cc. bag
- Glucose 100 Gm.
- Hydrocortone infusion 20 cc.

Drawer 20
- Gelusil liquid
- Maalox liquid

*Proprietary names are used in this article for the convenience of the reader.

where possible, of drugs which are available on the nursing station, the emergency box or the night drug supply cabinet.

A relatively simply program is to place the pharmacy staff on a "on-call" basis. If the medical and nursing staff use good judgment and not place unnecessary calls, this method will not create an undue burden upon the pharmacist. Where the hospital employs more than one pharmacist, the burden is thus proportionately reduced.

Hospitals having only one staff pharmacist have found it feasible to contract with local retail pharmacies for off-hour coverage. This coverage is provided for night and holiday relief for the staff pharmacist.

This method provides the hospital with the legal coverage necessary but may mean higher drug cost to the patient.

The drug inventory on the nursing stations commonly referred to as "floor stock" is usually assumed to be adequate for all general purposes. A few years ago this might have been true but modern therapeutics has changed the over-all concepts of the medical treatment of disease. Therefore, a review of the present "floor stock" by the Pharmacy Committee is essential. Once the inventory is adjusted to meet the current demand of modern therapy and diagnostic procedures, another step will have been taken to provide the nurse and the physician with the necessary agents for use during hours when pharmacy service is not routinely available.

Six methods for providing "after-hours" pharmacy service have been reviewed. No one system will provide the answer for every hospital; however, it is felt that the incorporation of a combination of the above described methods will provide a solution for the large majority of institutions. ■

Control of Ward Supplies in a Hospital Pharmacy

by Carroll R. Reinert

■ EFFICIENT DISTRIBUTION of pharmaceuticals and the preparation and distribution of drug supplies used daily in all departments of a hospital is the responsibility of every hospital pharmacist. Man-hours are lost and patient care can suffer when drug supplies are not available on the wards when needed. One solution to this problem, based on the principle of supply to meet demand, has been tried at Lincoln General Hospital, Lincoln, Nebraska.

This solution entails three factors:

1) Better organization of ordering supplies.

2) Efficient methods in preparation of articles which require compounding.

3) Rapid and simple means of dispensing these articles to the departments concerned.

Ward Supplies

Ward supplies are those drugs and other supplies kept on each nursing unit that are not labeled for a specific patient. The drugs are used so often and in such quantities that ordering them for individual patients would be too time consuming. Such ordering would also draw the nurse from her more important job of personal care of the patient. Thus small stocks are obtained from the pharmacy, put on ward stock, and then dispensed from the ward storage cabinet to the patient immediately when the need arises. The drugs include commercial items such as multiple dose injectables and commonly used tablets and capsules; items compounded by the pharmacy; and medications prepackaged into smaller units such as mineral oil or milk of magnesia. The pharmacy also dispenses to all departments bulk disinfecting solutions and soaps necessary for antiseptic conditions in the hospital and reagent solutions to the laboratory.

Mr. Reinert is hospital pharmacy resident, Lincoln General Hospital and graduate student in hospital pharmacy at The University of Nebraska, Lincoln, Nebraska.

Ordering of Ward Supplies

At Lincoln General Hospital, supplies are ordered by the different departments of the hospital on a standard drug requisition slip (*figure 1*) which has space provided for the amount, size, and description of each item, making deciphering of orders easier for the pharmacist. Space is also provided for pricing of the items to enable bookkeeping to be done rapidly without duplication of effort in recopying of items or charges to another form. The person ordering the items is identified so that any questions about the order may be quickly resolved.

Other types of order forms may be found in other hospitals—such as those in which every wardstock item is preprinted on the form. This requires only insertion of a checkmark or a quantity to order the item. Such form is quicker than a blank form, but is much less flexible in this period of constantly changing drug therapy.

The pathways of ward supply requisition are seen in the flow sheet (*figure 2*). A nurse responsible for the stock kept on the floor sends an order to the pharmacy dispensary for a number of items. The pharmacist fills the orders for commercial products kept in the dispensary and channels the requisition to either the pharmacy stockroom or the compounding laboratory. The compounding laboratory prepares a large number of the items ordered where practical and sends the amount ordered back to the nursing station. The excess goes to the pharmacy stockroom where future orders for these items are filled. Less commonly used commercial products and prepackaged items are also dispensed from the pharmacy stockroom. To facilitate speed in dispensing, all items are tagged with gummed stickers with the department name on it. The items are then delivered to the individual departments on the same day by messenger.

In some instances where an order can be only partially filled, a slip (*figure 3*) is sent to the department ordering the item, informing them of that fact, so that they may soon reorder. Also, if an item is not in stock at the moment, the appropriate blank on the same slip is checked and the item ordered from an outside supplier.

DRUG REQUISITION FORM
Lincoln General Hospital, Lincoln, Nebr.

Department of Pharmacy
DATE: 10-24-57 FLOOR: III West

Leave this column blank

NO.	SIZE	ITEM:	
1	24 oz	Milk of Magnesia	
2	gal.	Liquid Soap Solution	
1	100	Atropine Sulfate H.T. 1/150	
6	5cc	Multiple dose vials of Dimenhydrinate	

REMARKS
ORDERED BY: Jane Doe, RN

Fig. 1. Drug requisition form.

Compounding Procedures

Efficiency in compounding procedures denotes preparation of the right amount of the right substance at the right time, with little wasted motion. To determine this data, a survey was taken using the drug requisition slips. All compounded items on the requisitions were listed and the following two factors were recorded: (1) the total amount of each item used and (2) the total number of each size of container used in dispensing the items. This was done for three months to determine an average value for each quantity.

At the end of the three months, the items used in large enough volume to merit compounding or prepackaging were evident. The total

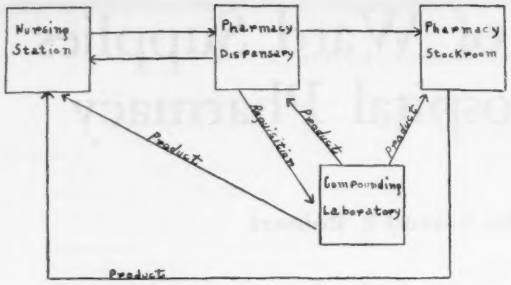

Fig. 2. Flow chart of ward supply requisition.

LINCOLN GENERAL HOSPITAL DEPARTMENT OF PHARMACY

To: III WEST

Regarding your order for Dimenhydrinate, 5 cc multiple dose vial

It is:

[X] Only partially filled. Please reorder.

[ ] Out of stock—will be sent to you upon arrival.

By C. Reinert

Date 10-14-57

Fig. 3. Form used to transmit information from the pharmacy department to the department placing order.

volume of each of these items per month was noted and the size needed most often was chosen as the standard size to be prepared or prepackaged. Past experience told us the right times of the year to make the item in quantity.

Bulk solutions used most often are made up in quantities to last approximately a month; a week's supply is compounded of those solutions used so often that storage of a month's supply would be a problem. Solutions with many ingredients are mixed in 12-gallon lots and dispensed from the 12-gallon bulk containers into the receptacles in which they are used in each department. Thus, by compounding in the largest volume that is practical, the output and efficiency of the pharmacy can be increased significantly and wasted motion can be reduced. Many routinely used smaller items, such as tablets, ointments, and small-volume liquid preparations are prepackaged by the compounding department, stored, and dispensed as needed.

Other systems of supply may have different routes and methods of moving supplies from the pharmacy to the user, or different items to compound and supply, but the common point in every method is the *organization* of that supply so that it will consistently meet the demand but will not overstock the department. This is best done by analysis of the demand, so that the organization which follows is done on a realistic basis and not on *estimated* values of usage. One may best judge the effectiveness of a floor supply control system by the comments of the nurses who rely on the hospital pharmacy for the materials with which they work.

The driving philosophy of a hospital pharmacy is that of the best service humanly possible to the patients of that hospital. Thus it is the pharmacist's moral obligation to aid the patient care as much as he can by offering to the hospital a smooth running system of dispensing those items used every hour of every day of the year—the floor supplies. ■

The American Hospital Formulary Service

by Daniel F. Moravec

Pharmacy Editor
Hospital Management

■ NOW FOR THE FIRST TIME it is possible for any hospital to establish and maintain an up-to-date formulary. The American Society of Hospital Pharmacists has available a Formulary Service by which all hospitals can economically have standardized drug usage programs with formularies which can be suited to *any hospital.*

A program of standardized drug usage opens the way to the fundamentals of the practice of modern hospital pharmacy. The formulary is the very basis of such a program and without it standardized drug usage cannot be successful. In other words, the formulary is essential for bid purchasing, optimal drug stock, minimal drug expenditures and unified effort between medical staff and pharmacy department. Also the formulary promotes more efficient patient therapy as well as lower costs of pharmaceuticals to the patient. These things can be done with the formulary as a basis and, at the same time, the hospital can realize its needed surplus income from its pharmacy department.

Prior to this Formulary Service, it was very difficult and expensive for most hospitals to establish and maintain up-to-date formularies, so much so that hospitals generally were not financially able to write, publish and keep up such system. The result then has been unfortunate in that standardized drug usage could not be efficiently practiced on a broad scale, because its foundation, the formulary, has been, for the most part, lacking.

Now it is possible for any and all hospitals to have their own formularies. The American Hospital Formulary is a loose-leaf collection of monographs which a medical staff and pharmacist (in the hospital having one) can use in preparing *its own formulary, for its own use.* The pharmacy committee of any hospital can use the drug monographs it wants and can omit those not wanted. The important factor is that drug monographs are prepared and ready for selection and this is a great percentage of the battle in formulary preparation and maintenance.

This new booklet is designed to provide a convenient reference for physicians, nurses, and pharmacists regarding drugs, their dosage forms, and toxicity and unusual procedures or precautions which may be necessary in their administration. Helpful and meaningful descriptions of each drug, its actions and uses, dosage and preparations are stated concisely.

Drug monographs for the American Hospital Formulary are being prepared by Dr. William M. Heller, chief pharmacist of the University of Arkansas Medical Center at Little Rock. Dr. Heller, as chairman of the Committee on Pharmacy and Pharmaceuticals of the American Society of Hospital Pharmacists, is in charge of the project. Dr. Heller is being assisted by Dr. Marc Jor-

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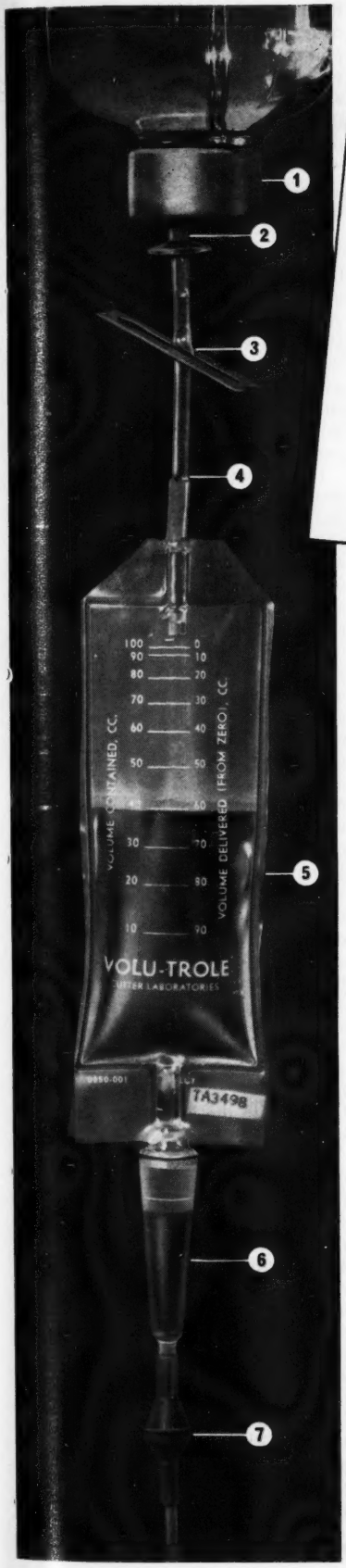

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accurate	permits precise measurement of solutions for intravenous administration
efficient	provides accurate control of both fluid volume and drip rate
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safe	sterile, pyrogen free, ready to use

Illustration

1. Dispensing Flask
2. Bottle Connector Spike
3. Metal Shut-off Clamp
4. Medicinal Entry Tubing
5. Measuring Chamber
6. Dripmeter
7. Saftibulb*

*T.M.

Also available: The Volu-Trole SAFTIFILTER* for accurate control of pediatric blood infusion therapy.

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CUTTER LABORATORIES, Berkeley, California

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Carithers

Continued from page 39

This is the type of question which requires serious investigation. First of all, it is difficult to find general agreement on what specific drugs might fall into this classification of so-called "dangerous" drugs. The length of time after which an automatic stop order would become effective proved another question. And, lastly, the advent of this type of an administrative "control" was not a popular development with most members of the medical staff. The administration of such a program also would place a burden upon nursing personnel who would be reluctant to automatically cancel an order for medication without contacting or informing the physician.

As a result, these matters were all considered by the committee and a workable plan evolved. The program was sold to the medical staff and has been working effectively.

Nursing Interests

We feel that the Pharmacy Committee should work closely with all departments of the hospital involved in drug administration in any form. The Nursing Service Department, of course, is vitally concerned with drug usage and has the constant problem of being called upon to administer certain drugs which they feel that as graduate nurses they are not qualified to give. Drugs which they have questioned are referred to the Pharmacy Committee. The committee thoroughly reviews the clinical data on each drug, reported reactions and other details. The result has been an approved and posted list of drugs which are to be administered by a physician only. This list is reviewed from time to time as new questions arise, and certain drugs are often deleted as well as new ones added to the list.

The list of emergency drugs to be stocked on each nursing unit is reviewed annually by the committee with special problems or requests considered as they arise. This can be quite a problem on some units and the emergency room is a good example. The emergency room is staffed principally by interns and residents. Each new group seems to feel the need for considerable changes in drugs stocked in the emergency area. These requests must be investigated and judged on the basis of both need and experience.

Questions arising from individual members or from the respective services of the medical staff regarding drug policy are referred to the Pharmacy Committee for investigation. This serves to keep the members of the committee aware of the details of drug administration in the hospital. A recent request led our committee to investigate the entire system for drug charges to inpatients, accounting for unused drugs and credits to the patients' accounts. Recommendations were made which improved the system and assured a more accurate control of patient drugs on the individual nursing units.

Drug Formulary

There are many other matters considered by Pharmacy Committees in hospitals, but which might not have been considered by our own committee. One of these is the adoption of a drug formulary for the entire hospital. This is one of these important, but controversial questions for which proponents claim distinct advantages both in adequate drug therapy and in costs of drugs to the patient. However, we feel that the importance of the varying situations must be considered: the size of the attending staff, the tradition of pharmacy service, the important task of staff education.

In many instances, the efficient operation of the pharmacy excludes drugs in disuse, drugs of questionable manufacture, and unnecessary duplication without an official formulary. If the price of drugs is the prime reason for considering a formulary, the committee must realize that the hospital pharmacy can ill-afford to be the leader in cut-rate drug sales in the community. With or without a formulary, however, the Pharmacy Committee should be well informed of practices in drug procurement, processing, and distribution in the pharmacy as well as use of the drug.

One inherent difficulty in the make-up of the Pharmacy Committee is the natural tendency of the private physician member to draw almost exclusively from his own personal experience in making what might be an important decision affecting all members of the medical staff. His inability to develop broad institutional concepts cannot be compensated for by excellent intentions. The effects of this problem can readily be seen should the committee be attempting to develop a formulary. Unless the committee is composed of exceptional persons, the tasks of establishing the specific drugs to be included in the formulary often fall to the pharmacist who is usually the best informed and most widely read member of the committee in matters of therapeutics. The pharmacist does not want to be placed in this position.

Open Staff

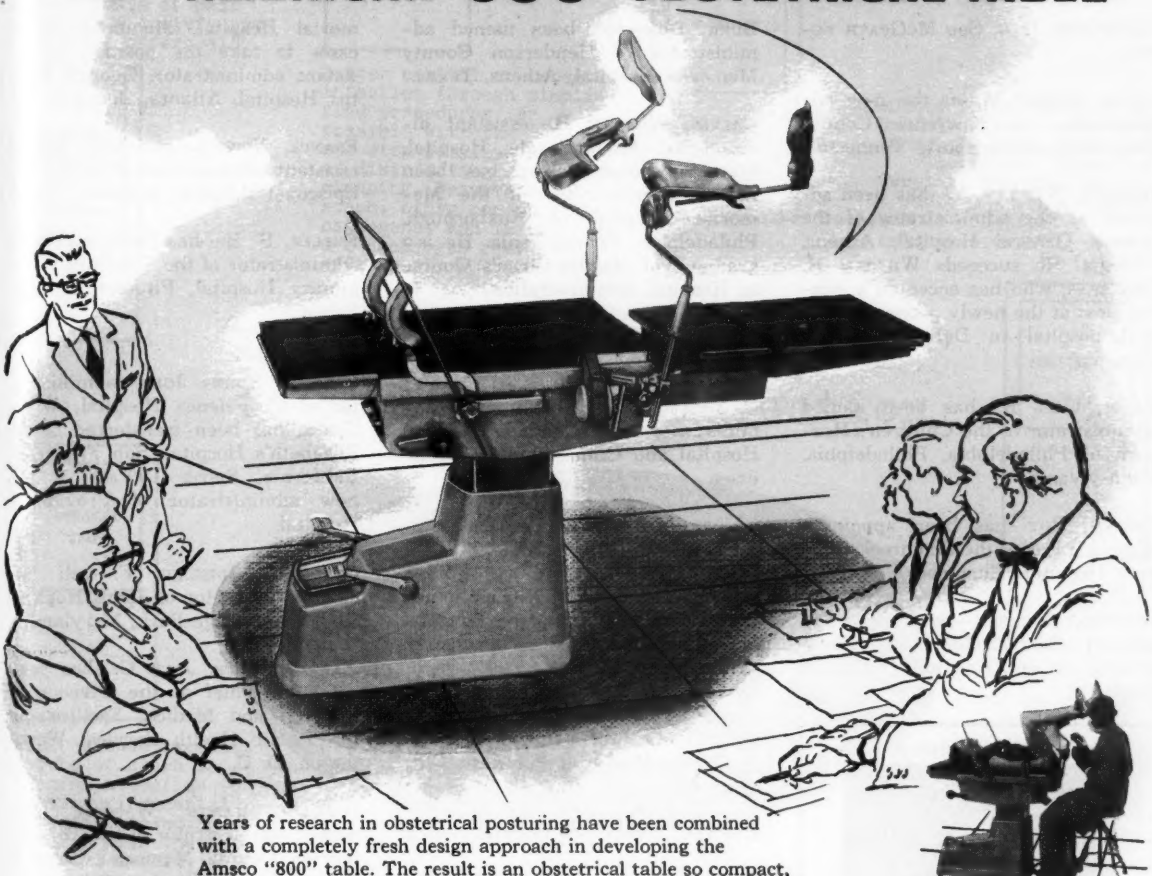
In a voluntary, nonprofit general hospital with an open staff of qualified physicians, the problem of developing institutional concepts and attitudes is somewhat more evident than in the closed staff hospital where the physician's very existence as a staff member may depend, in part, upon this type of thinking and participation.

In the open staff hospital, the democratically organized medical staff is truly a volunteer organization. The burden of making wise and judicious appointments of members to committees falls to the president of the staff. Proponents of the strong Pharmacy Committee insist that the president remain above any personal considerations, political obligations or past favors in making appointments to this committee. He must appoint only those who are genuinely interested in drug therapy and management. These are noble principles which the staff president would like to uphold, but they are not very practical. It would be the exceptional staff were the president able to make appointments solely on this basis, for he must use the same principles in the appointment of members to such important committees as the tissue, laboratory, resident staff, medical records and others. He is subject to the pressures of a democracy and the necessity for broad representation. This fact must be recognized in assigning functions to the Pharmacy Committee.

In a large and highly organized medical staff it is questionable that the Pharmacy Committee should conduct a review and evaluation of the medical record with regard to adequate drug therapy. The medical record today is probably the most handled and mishandled primary document in existence, and in the process it is thoroughly reviewed by several committees and by many persons. Matters involving drug therapy can and are being referred to the Pharmacy Committee by other committees. Medical record librarians are now beginning the reporting of drug reactions which

Please turn to page 70

Presenting THE ALL NEW AMERICAN "800" OBSTETRICAL TABLE



Years of research in obstetrical posturing have been combined with a completely fresh design approach in developing the Amsco "800" table. The result is an obstetrical table so compact, so maneuverable and so efficient as to be truly revolutionary in its advantages for operative as well as perineal route delivery.

From the narrow, flowing lines of the flexible top to the *permanent* or *portable* power base . . . the "800" is *new*.

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Every Feature

- **finger-tip controls**
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Unobstructed surgical approach

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Who's Who

ALTSHULER, DAN. See McGRATH notice.

ASTIN, CARDIN M.—is the new administrator of Lawrence County Hospital, Lawrenceburg, Tennessee.

BARRETT, WILLIAM A.—has been selected as the administrator of the Athens General Hospital, Athens, Georgia. He succeeds WILLIAM H. THRASHER, who has accepted a similar post at the newly proposed general hospital in DeKalb County, Georgia.

BAUM, CARL R.—has been named administrator of the Children's Hospital of Philadelphia, Philadelphia, Pennsylvania.

BERTEN, ROY—has been appointed administrator of the Shamrock General Hospital, Shamrock, Texas.

BOWNDS, JACKSON—has been appointed administrator of the Richards Clinic and Hospital, Rockdale, Texas.

Editorial Advisory Board

Dr. Ray E. Brown

HOSPITAL MANAGEMENT announces with pardonable pride the appointment of Dr. Ray E. Brown to its Editorial Advisory Board.

Dr. Brown is superintendent of the University of Chicago Clinics, professor of Hospital Administration at the University of Chicago, a regent of the American College of Hospital Administrators and a former president of the American Hospital Association.

Charles U. Letourneau, M.D.

BURK, DON—has been named administrator of Henderson County Memorial Hospital, Athens, Texas.

CALVIN, WILLIAM B.—assistant director of Mountainside Hospital, Montclair, New Jersey has been named administrator of the Memorial Hospital of Roxborough, Philadelphia, Pennsylvania. He is a graduate of Northwestern's Course in Hospital Administration.

CASH, MISS WINNIE. See WILLIS notice.

CHISHOLM, DARRELL—is the new administrator of Sequatchie General Hospital and Clinic, Dunlap, Tennessee.

COATES, MRS. HELEN. See ELLIS notice.

COBBIN, ALEXANDER D.—has joined the staff of the University Hospital of Seattle as administrative assistant to the administrator.

CONTOS, DOUGLAS—has been appointed business manager of Louis A. Weiss Memorial Hospital, Chicago, Illinois.

DEPAUL, SISTER. See GABRIEL notice.

DUVAL, DR. ADDISON M.—has accepted the appointment as director of the Missouri State Division of Mental Diseases, Jefferson City, Missouri.

DYE, W. J.—has been appointed administrator of Woodcroft Hospital, Pueblo, Colorado.

ELLIS, WALTER W.—has succeeded MRS. HELEN COATES as administrator of the Alexander Linn Memorial Hospital, Sussex, New Jersey. He comes to Linn from the Memorial Community Hospital in Edgerton, Wisconsin.

FARNSWORTH, CHARLES F.—has been appointed administrator of the Nassau County General Hospital in Fernandina Beach, Florida.

FORE, ROBERT E.—resigned as administrative assistant at Baptist Memorial Hospital, Memphis, Tennessee to take the position of assistant administrator, Georgia Baptist Hospital, Atlanta, Georgia.

FRANCE, NEWELL—has been named assistant administrator of St. Luke's Episcopal Hospital, Houston, Texas.

FULLER, S. B.—has been appointed administrator of the Pittsburg Community Hospital, Pittsburgh, California.

GABRIEL, SISTER JOHN—administrator of Providence Hospital, Waco, Texas, has been transferred to St. Elizabeth's Hospital, San Francisco, California. SISTER DEPAUL is the new administrator of Providence Hospital.

GRAPSKI, LADISLAUS F.—will become the director of Johns Hopkins Hospital, College Park, Maryland.

HALDEMAN, DR. JACK C.—has been appointed chief of the Division of Hospital and Medical Facilities of the Public Health Service, Washington, D. C.

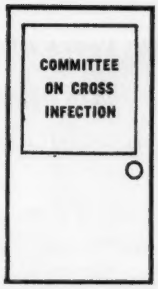
HICKLIN, JAMES W.—has been named administrator of the Throckmorton County Memorial Hospital, Throckmorton, Texas.

Dr. Hoge

HOGE, DR. VANE M.—has been appointed executive director of the Hospital Planning Council for Metropolitan Chicago, Chicago, Illinois. He was formerly assistant surgeon general of the United States Public Health Service.

JONES, EDWARD B.—has been named assistant administrator of Passavant Hospital, Pittsburgh, Pennsylvania.

Sufficient detergency to satisfy the Housekeeper, efficient disinfection to satisfy the Professional Staff, lighter labor costs to satisfy the Administrator, and minimum costs of best supplies to satisfy you – Tergisyl offers all.

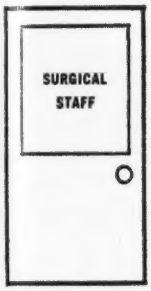


Better control of cross infection through simplified procedures is possible with the one-step Tergisyl method of disinfecting and cleaning. Reservoirs of staph, other common pathogens, and TB bacilli are destroyed routinely, efficiently with less effort.

For every 100,000 square feet of floor space in your hospital now cleaned and then disinfected by man-and-mop-and-pail, you can save as much as 5 man days per week, or 40 man hours, by adopting the one-step Tergisyl method.

Complete twice the work in half the time – and save money on both labor and materials. One-step Tergisyl cleaning procedure – which includes dependable disinfection – is quickly accepted, easier to follow.

Lehn & Fink's new weapon to combat cross infection



Best defense against spread of staph is careful attention to total environmental asepsis, including floors. With the Tergisyl method, efficient general disinfection is simultaneous with routine cleaning.

Tergisyl T.M.

DETERGENT–DISINFECTANT

Cuts labor cost 47%

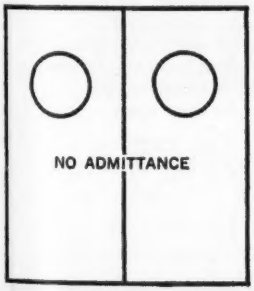
(by mop-and-pail method)

Cuts labor cost 22%

(by machine scrubbing-vacuum method)

Cuts material cost 5% to 10%

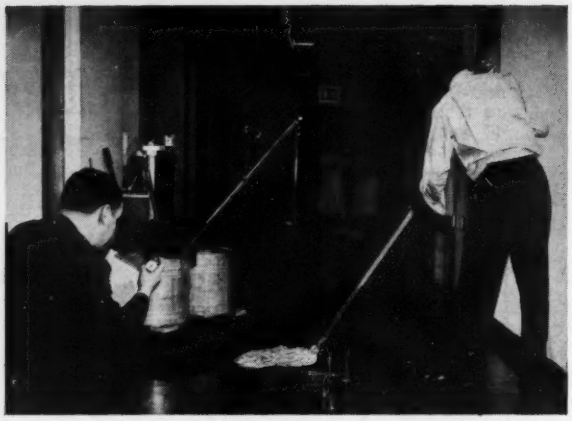
(using either of above cleaning-disinfecting methods)



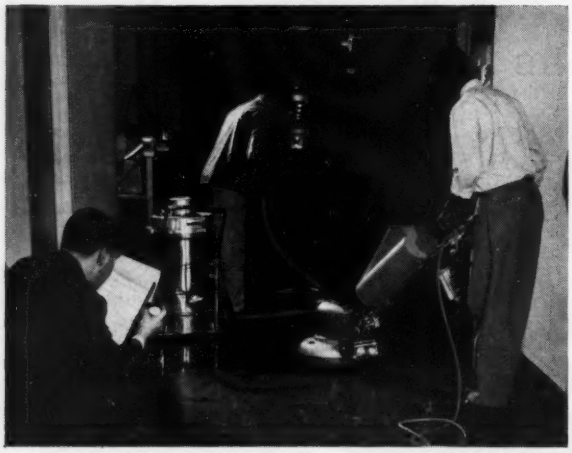
Keeping the O.R. "clean" in every sense of the word is easier, quicker with the new Tergisyl technic. Efficient disinfection and dependable detergency are combined in one cleaning step to achieve environmental asepsis you can be proud of. Has no effect on conductivity.

For details of comparative time studies under actual hospital conditions—

TURN PAGE



Comparative time studies of Tergisyl vs. conventional method washing and disinfecting using mop-and-pail technics. One-step Tergisyl method reduced the man-time required by 47%. Actual time saved was approximately 25 minutes per 1,000 square feet of floor area—a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.



Comparative time studies of Tergisyl vs. conventional machine scrubbing vacuum pickup, and mop-and-pail application of disinfectant. One-step Tergisyl method reduced the man-time required by 22%. Actual time saved was approximately 23 minutes per 1,000 square feet of floor area—a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.

Comparative cleaning and disinfecting efficiency of Tergisyl vs. conventional method. Subsequent inspection showed greater cleaning ability for Tergisyl than the detergent previously judged acceptable by the hospital. "Before" and "after" bacteriological tests confirm germicidal efficiency of Tergisyl.

Three years of research backed by over sixty years of experience have produced Tergisyl , detergent-disinfectant

Since control of cross infection, especially from Staph, has become a major problem for hospitals, Lehn & Fink has felt an increasing responsibility to do everything possible to aid in this fight. Producing the most efficient disinfectants for hospital use has been our chief concern for many years. In addition, we have tried to supply these disinfectants in as practical and easy-to-use a form as possible so that the hospital could devote its attention to actual medical and surgical care of the patient.

Seriousness of the Staph problem has now made more adequate and dependable disinfection a necessary part of patient care. Development of Tergisyl, combining the comprehensive bactericidal, fungicidal, tuberculocidal efficiency you have come to expect of our products with sufficient detergency to clean even heavy soil satisfactorily, took many years of research. An independent research organization has confirmed our findings under actual hospital conditions.* But the most convincing test of Tergisyl's labor-saving advantages is use in your own hospital. We hope you will try it. Why not write immediately for your free sample and literature?

*Details of report available on request.

For metered mixing of Tergisyl and water in the proper proportions directly from the faucet—Use the L&F ECONOMIX™ PROPORTIONER

No more mixing and measuring. With the press of a button, the right proportion of Tergisyl is automatically released with the cleaning water. A carefully designed, stainless steel attachment which saves time, assures efficient use dilution every time. Same faucet can still be used for clear water.

Write for Tergisyl brochure and additional information about the convenient Economix.

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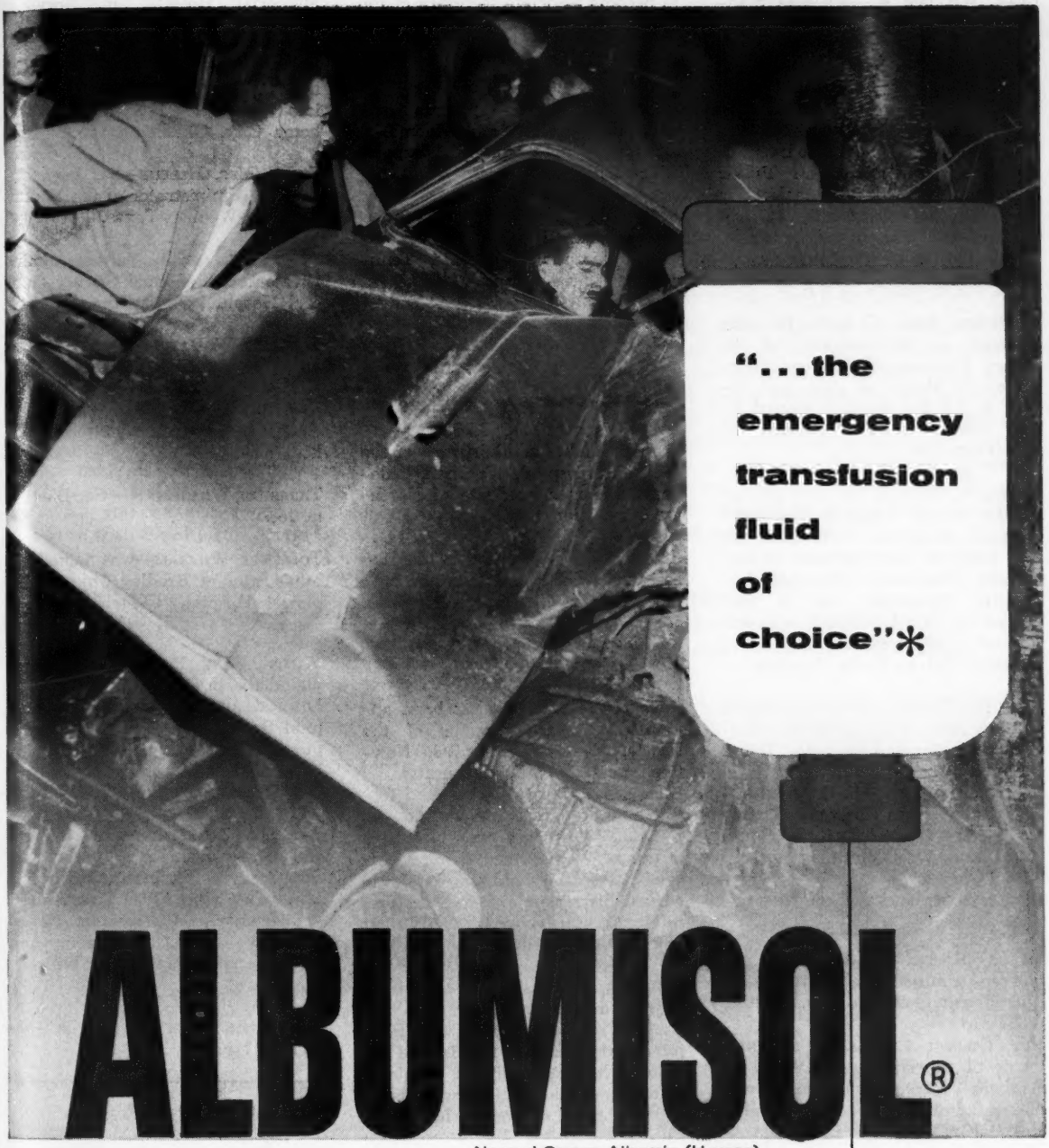

Normal Serum Albumin (Human)

No risk of serum hepatitis
Ready for administration; no storage problems
Human protein; readily metabolized
Contains no blood-clotting components
No grouping, typing, cross-matching required

Supplied: 'ALBUMISOL' 5%—in 250 and 500 cc. bottles in packages with a set of disposable intravenous equipment.

Also supplied: 'ALBUMISOL' 25% (Salt-Poor)—in 20 cc. bottles; in 50 cc. bottles in packages with a set of disposable intravenous equipment.

*Janeway, C.A.: Quart. Rev. Med. 9:153 (Aug.) 1952.

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LEAK, WILLIAM W.—assistant manager of the VA Hospital at Augusta, Georgia has been appointed manager of the VA Hospital at Muskogee, Oklahoma.

LEMBCKE, DR. PAUL A.—has recently been appointed professor of Preventive Medicine and Public Health at the Medical School of the University of California at Los Angeles and also at the School of Public Health of the University of California.

MCGARRY, MRS. CLARICE H.—who resigned as administrator of the Valley Hospital, Ridgewood, New Jersey in March of 1957, will return to fill the vacancy caused by the resignation of WILLIAM E. WORCESTER, JR.

MCGRATH, DON—is the new administrator of the Crippled Children's Hospital, Knoxville, Tennessee. He was formerly administrator of La-Follette Community Hospital, La-Follette, Tennessee and is succeeded by DAN ALTSHULER, who was formerly administrator of Sylva Hospital, Sylva, North Carolina.

MANLEY, R. W.—has been named administrator of the Littlefield Hospital and Clinic, Littlefield, Texas.

MATTIX, GEORGE I.—is the new administrator of the Herbert J. Thomas Memorial Hospital, South Charleston, West Virginia.

MULLENBACH, IRVIN J. See WOLF notice.

MYERS, ROBERT J.—has been appointed administrator of the General Hospital, Seattle, Washington.

NEE, GILBERT C.—former administrator of the Hartland Hospital in Baldwin Park, California, was named administrator of the Valley Hospital in Van Nuys, California.

NEWSOME, BILL—has been appointed administrator of D. M. Cogdell Memorial Hospital, Snyder, Texas.

NICHOLSON, ROBERT—administrator of the Dade County Hospital has been named director of Public Welfare of Dade County, South Miami, Florida. He was also elected president-elect of the South Florida Hospital Council.

NUNEMAKER, DR. JOHN C.—director of the Education Service in the VA Department of Medicine and Surgery in Washington, D. C., has left to become associate secretary of the American Medical Association Council on Medical Education and Hospitals in Chicago, Illinois.

O'MEARA, JOHN V.—appointed administrator of Riverside Memorial Community Hospital, Waupaca, Wisconsin.

POWELL, JOSEPH H.—was named assistant administrator of Baptist Memorial Hospital, Memphis, Tennessee.

PRICE, MISS ELIZABETH, C.R.L.—has been appointed as director of Medical Records at Presbyterian-St. Luke's Hospital, Chicago, Illinois.

REEVE, ROBERT D., M.S.H.A.—has been appointed administrator of the Jackson Hospital, Jackson, Alabama. He is a graduate of Northwestern University.

RILEY, LEROY F.—has resigned as assistant director of Research Hospital, Kansas City, Missouri to accept the post as administrator of the Hospital of the Pines Lone Star, Morris County, Texas.

ROBINSON, EDWIN J.—has been appointed assistant director of the Newton-Wellesley Hospital, Newton Lower Falls, Massachusetts.

SHEPPECK, COL. MICHAEL L. F.A.C.H.A.—is the new executive officer of Walter Reed Army Medical Center in Washington, D. C. He earned his master's degree in Hospital Administration in 1949 at Northwestern University.

SIMMONS, WILLIAM G.—has been appointed administrator of the Battle Creek Sanitarium and Hospital, Battle Creek, Michigan. Previously he was assistant administrator, and prior to that was active in the hospital equipment field.

Mr. Slabonick

Mr. Wolf

SLABONICK, WILLIAM—has resigned his post as assistant administrator of the Massillon City Hospital, Massillon, Ohio, to accept the post of administrator of the Fisher-Titus Memorial Hospital in Norwalk, Ohio.

SPRINGALL, DR. ARTHUR N.—is the new director of Professional Services of the VA Hospital in Oklahoma City, Oklahoma.

STECH, MRS. HELENE—has been appointed administrator of the Youens Hospital, Weimar, Texas.

STOUT, WILLIAM J.—became administrator of the Henry County General Hospital, Paris, Tennessee.

STREETER, W. DAVID—the comptroller of the Jewish Chronic Disease Hospital in Brooklyn, New York, has assumed the additional position of associate executive director of the hospital.

THRASHER, WILLIAM H.—See BARRETT notice.

TORRENCE, WILLIAM—was named administrator of Bradley County Memorial Hospital, Cleveland, Tennessee.

WILLIS, JOHN R., B.S.—who completed the preceptorship training in hospital administration at Rex Hospital last September, was appointed purchasing agent of Rex Hospital in Raleigh, North Carolina. He replaces MISS WINNIE CASH.

WOLF, EARL C.—administrative assistant and director of purchases at St. Mary's Hospital, Rochester, Minnesota since 1939 has retired. MR. IRVIN J. MULLENBACH, former assistant purchasing agent and stores department manager will succeed him.

WORCESTER, WILLIAM E., JR.—See MCGARRY notice.

Correction

Mr. Jack Hahn

Dr. M. W. Hyde

On page 32 of the August issue we misidentified the picture of Mr. Hahn. The photo printed was that of Dr. Melvin W. Hyde, president of Evansville College. Our apologies.

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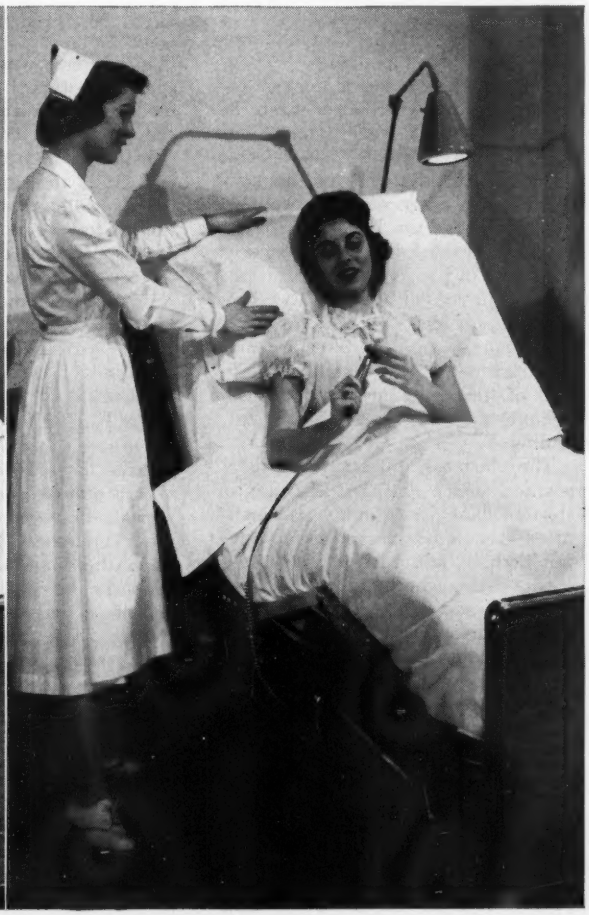

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Hospitals and the Law

by Emanuel Hayt, LL.B.

Manufacturer Liable for Contaminated Blood Plasma Deemed Filthy

■ THE APPELLEE (patient) was injured when his leg came in contact with a power saw. His injuries were severe, consisting of a large cut in his right thigh extending down to the bone. He was taken in a state of shock to a hospital in Knoxville, Tennessee, where his wife signed on his behalf a consent to any medical or surgical procedure the surgeon or physician in charge of his case might deem necessary. Because of the appellee's condition the hospital's resident surgeon administered a quantity of blood plasma before performing emergency surgery. The plasma had been manufactured by the appellant.

The appellee made a normal recovery and was discharged from the hospital about a week later. Some two months thereafter, he became afflicted with jaundice, and his condition was diagnosed as probably homologous serum hepatitis. He was confined to a hospital for several days and to his home during a long period of convalescence. The jury determined that this illness had been caused by the blood plasma administered to him upon the occasion of his leg injury, and the appellant does not now dispute that finding.

The plasma in question is a dried powder which by the addition of sterile water is quickly reconstituted into liquid blood plasma which can then be administered as a substitute for whole blood. It has marked advantages over whole blood, particularly for emergency use. Among these advantages are its stability, and the fact that it can be administered safely without first determining the blood type of the recipient.

The manufacture of blood plasma is regulated by the United States Department of Health, Education and Welfare under the Virus, Serum and Toxin Act, 42 U. S. C. A., § 262.

The Tennessee Food, Drug and Cosmetic Act is patterned upon the Federal Food, Drug and Cosmetic Act. It prohibits, among other things, the sale or delivery within that state of any food, drug, device, or cosmetic that is "adulterated." § 52-103(a), Tenn. Code Anno. The plasma unquestionably was a "drug" as defined by the statute, § 52-102 (d), Tenn. Code Anno. A drug is "adulterated" under the statute "if it consists in whole or in part of any filthy, putrid, or decomposed substance." § 52-115, Tenn. Code Anno.

The appellee's theory was that the plasma in question was adulterated because the virus which it contained was a filthy substance. The district court admitted the testimony of several physicians upon the question of whether the virus was "filthy." The effect of this evidence was inconclusive, except to establish that there is no medical or scientific definition of the term. The court submitted the question to the jury for determination. It is the appellant's manufacturer's claim that this was a question of law to be determined by the court, and that as a matter of law Manufacturer liable for .... to be determined by the court, and that as a matter of law the hepatitis virus is not a "filthy" substance within the meaning of the statute.

There have been no adjudications by the courts of Tennessee involving the meaning of these provisions of the statute. Both parties to this appeal, however, agree that since the Tennessee law is patterned upon the Federal Act, resort may properly be had to federal court decisions construing the latter statute. The meaning of "filthy" is the subject of a number of decisions by the federal courts in cases involving food, and the courts have apparently been unanimous in holding that the term is not synonymous with "injurious to health" or "unfit for food." The fact that hepatitis virus is injurious is thus clearly irrelevant to the question of whether or not it is filthy. Similarly, since filthy is not synonymous with "infected" or "diseased," the trichinosis cases arising under state food and drug laws, relied upon by the appellee, shed no light upon the question in issue.

The federal decision which comes closest to supporting the meaning which the appellee would ascribe to the term "filthy" is *United States v. Sprague*, 208 Fed. 419 (SD N. Y., 1913). That was a case decided under the Federal Pure Food and Drug Act of 1906. The court held that bacteria, particularly the *Bacillus typhosus*, which had been absorbed by live oysters during their process of growth, rendered them filthy, "especially since the result of investigation has shown that filth or dirtiness is dangerous through the germs which it contains, and not solely because of offense to the senses." 208 Fed. 421. That decision is differentiable for the reason that the bacillus there involved is microscopically detectible, and, as the appellant suggests, perhaps also because the typhoid bacillus was transmitted to the oysters in human sewage and other filth.[1]

"Ascribing to words their ordinary meaning, as exemplified by the cases cited, we agree with the appellant that a virus which cannot be seen even with the most powerful microscope, which cannot be described, and the presence of which cannot be known at all except for its ultimate results, is not a filthy substance within the intendment of the statute. For this reason we hold that the district court was in error in failing to direct a verdict for the appellant. This conclustion makes it unnecessary to consider the question of assumption of risk and the effect of the independent intervening act of the physician, as well as other questions raised by the appellant.

"The judgment is set aside, and the case is remanded with directions to enter a judgment for the appellant."

(Merck & Co., v. Kidd, 6CCH Neg. Cases 2d 1233—Tenn.)

Please turn to page 80

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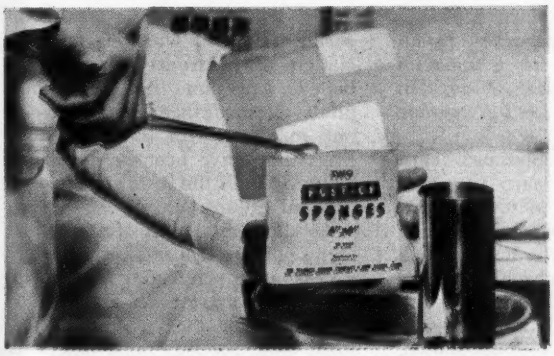

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Medical Records

by Edna K. Huffman, C.R.L.

All Reports Should be in Medical Record

***QUESTION*: Should sutures of lacerations done under local anesthesia (regardless of the extent of laceration or number of sutures); aspirations done under local anesthesia; manipulations or reductions of fractures and dislocations without anesthesia; and injections into a joint, bursa or nerve, with procaine, novocaine, cortril, alcohol or such be documented and attached to the patient's medical record? M. M. M.**

ANSWER: The medical record should be complete documentary evidence of the care and treatment given a patient in the hospital. Therefore, a complete report of every treatment given whether medical or surgical, with or without anesthesia should be recorded in the medical record irrespective of where else in the hospital the same information may be recorded. Only in this way will the medical record serve a means of communication between the physician and everyone else contributing to the care of the patient. Where these facts are documented in the medical record should be determined by the policy of the hospital, and its medical staff.

Patient-Days

***QUESTION*: What is the basic difference between days of care to patients in the hospital, and days of care to patients discharged? Are the terms synonomous, or are they used for different statistical purposes? B. M.**

ANSWER: These terms are not synonymous. The *days' care rendered to patients in the hospital* is that period of service rendered one inpatient between the census taking hours, usually midnight, on two successive days. For instance, the census at midnight was 30. This indicates that 30 patients received one patient-day's care each on that day. Thus a total of 30 patient-days' care was rendered that particular day to patients who were in the hospital when the census was taken. However, two patients were both admitted and discharged that day also, and for that reason would not be shown on the midnight census. They too would have received one day's care each. Therefore, the total patient-days' care rendered that particular day would be the sum of 30 and 2, or 32 days. Because these figures are compiled from the census they are many times called "census-days." *The daily average number of patients,* also sometimes referred to as the average daily census, is figured from these totals and is the sum of the patient-days' care rendered each day during the month divided by the total days in that month.

The *days of care rendered to discharged patients* are collected from the medical records after discharge of the patients. Here, the day of admission is counted but not the day of discharge, unless the patient was admitted and discharged the same day. Thus, if a patient was admitted May 4th and discharged May 14th his stay would have been 10 days. If a patient was admitted May 4th and discharged June 6th his stay would have been 33 days. The sum of the day's care rendered to all discharged patients for a month divided by the number of days in that month will give the *average length of stay.*

The comment is sometimes heard that when there are many long-stay patients a distorted picture results. The picture is not distorted although it may well be that the hospital will find that too many chronic patients are occupying beds needed for acutely ill patients. If the long-stay cases are deducted this is not shown. However, if the hospital has a section specifically set aside for chronic patients it might then consider figuring the average length of stay two ways: for short-term patients, and for long-stay cases.

Signatures for Authorization

***QUESTION*: Is the husband's signature acceptable on the surgical permit for his wife, if she is able to sign it herself? Also is the signature of a husband acceptable on an authorization for release of information for insurance purposes? S.R.A.**

ANSWER: The patient is the only one who has the right to authorize an operation on his own person, or to release information from his own medical record unless physically or mentally incompetent. However, there are certain types of surgery in which it is advisable for the hospital to require signatures from both the husband and wife as in sterilizations on either party, and therapeutic abortions.

Standardized Insurance Forms

***QUESTION*: We are having difficulty with some insurance companies in this area when using the standardized group and individual insurance forms. This is due primarily to the fact that some have a form to be completed by the employer printed on the back of their form, and others have this information crowded in on the front. Have the insurance companies agreed to the use of the standardized forms? J.A.M.**

ANSWER: These forms were originally developed by the Health Insurance Council which is an association of insurance companies, I believe. I presume that as with hospitals all insurance companies will not go along with the idea. However, they have been accepted officially by both the insurance and the hospital groups.

As the completion of varying styles of insurance forms, which necessitate much leafing through the medical record, creates a great burden in the medical record department each hospital must determine whether it can afford to provide the secretarial assistance necessary to give the insurance companies as much data as they want.

The use of standardized forms is an added advantage to the hospital in that it allows a duplicate copy to be made for filing with the record. However, caution must be exercised to see that the copy with the patient's signed authorization is used as the duplicate which will be filed with the record.

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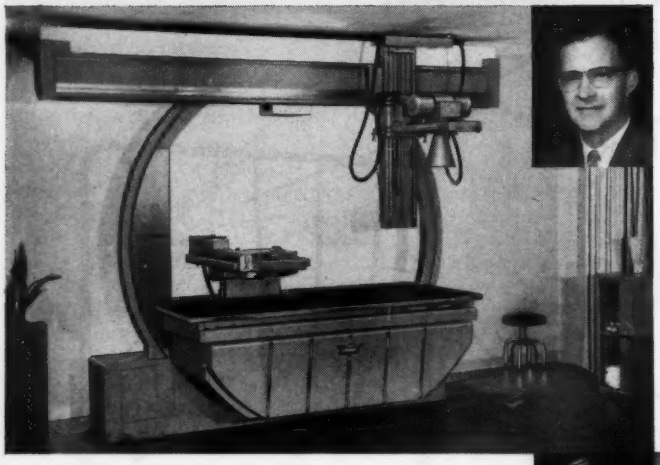

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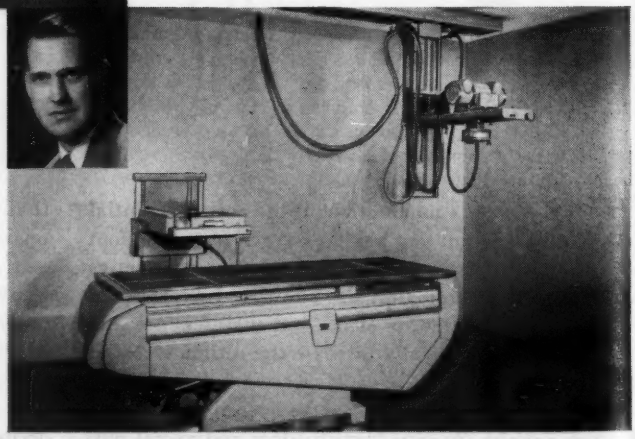
"Many I talk to describe the Regent as the backbone of their x-ray department," explains R. D. Newell, Providence, R. I. "It's really amazing how this one stands the gaff of hard use, day-in, day-out. My installations show a consistent history of solid performance with little attention. My radiologist friends like the smooth, adjustable-speed angulation through 45° Trendelenburg . . . the obstruction-free design . . . Regent's convenience for consultations and resident training. What does it take to interest a radiologist in a Regent? Just the chance to try one, I find."



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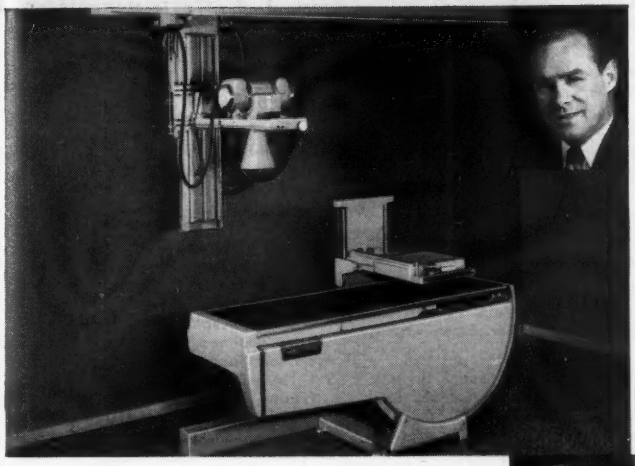

THE ARISTOCRAT

"I call the Aristocrat a *lot* of x-ray equipment for the price," says J. W. Heller, Topeka, Kan. "I often recommend its economy for both private and hospital practice — who can match it? Full diagnostic range... 15° Trendelenburg table... overhead tube hanger... automatic spot-film device... sealed spot-film phototimer. Aristocrat has the features radiologists need! They like the full-size table too... aren't forced to shove patients into freak positions. Of course, they also appreciate the backing of traditional General Electric cooperation when they need to call on us."

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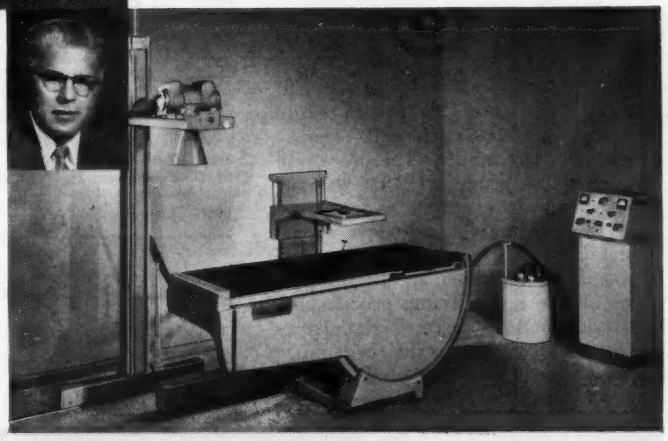

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Letourneau

Continued from page 47

premature infants in his hospital with the standards set by the American Academy of Pediatrics, the administrator can determine whether any changes are needed. He should ask himself these questions:

Are oxygen analyses being done at least every four hours?

Are results of analyses being recorded?

Are the physicians prescribing oxygen in enough detail for proper administration?

Is there periodic servicing and maintenance of all oxygen equipment?

Do all members of the nursing and medical staff in the premature nursery understand the principles of oxygen administration and have practical skills in handling oxygen equipment?

Do the patient observations include all the proper areas of response to oxygen therapy?

If this review reveals any weakness, the administrator must initiate the necessary adjustments. Once he is certain that a high level of performance has been attained, the administrator must see that it is maintained.

Staff Education

In providing good oxygen therapy to premature infants, the most important element is well-trained personnel. Despite the fact that the hospital has adopted standard procedures, a person who is unqualified or inadequately prepared could easily administer harmful concentrations to infants. Therefore, an educational program under the supervision of the physician in charge of the premature nursery is essential. Teaching and guiding new staff members, both medical and nursing, should be a continuing process. In-service classes on the administration of oxygen to the premature infant and the associated medical problems will enhance the knowledge and interest of the staff. Periodic conferences of the medical and nursing personnel with the oxygen therapy technician can help to solve therapy problems, as well as offer an opportunity for an exchange of information. Standard procedures for the administration of oxygen, both routinely and in an emergency, should be written as hospital policy and made available to all concerned. Methods of cleaning and disinfecting equipment should also be written up as standard procedures.

A premature infant's life and chance for proper development is mainly in the hands of the medical and nursing staff. Their skills and knowledge guide the infant to safe and healthy maturity.

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Carithers

Continued from page 56

should prove valuable to this committee as well as for other uses.

There are many advantages to the operation of the Pharmacy Committee. We believe the greatest is its existence as a *forum* which brings together the *medical staff, pharmacy, hospital administration* and other hospital departments for the consideration of problems of mutual concern. It also recognizes the pharmacist as a key member of the patient-care team. It assists the pharmacist and the administration by providing medical staff backing for decisions or proposals affecting drug policy. These, of course, are practical advantages. But in the background of each is the over-all advantage of a safeguard for good patient care.

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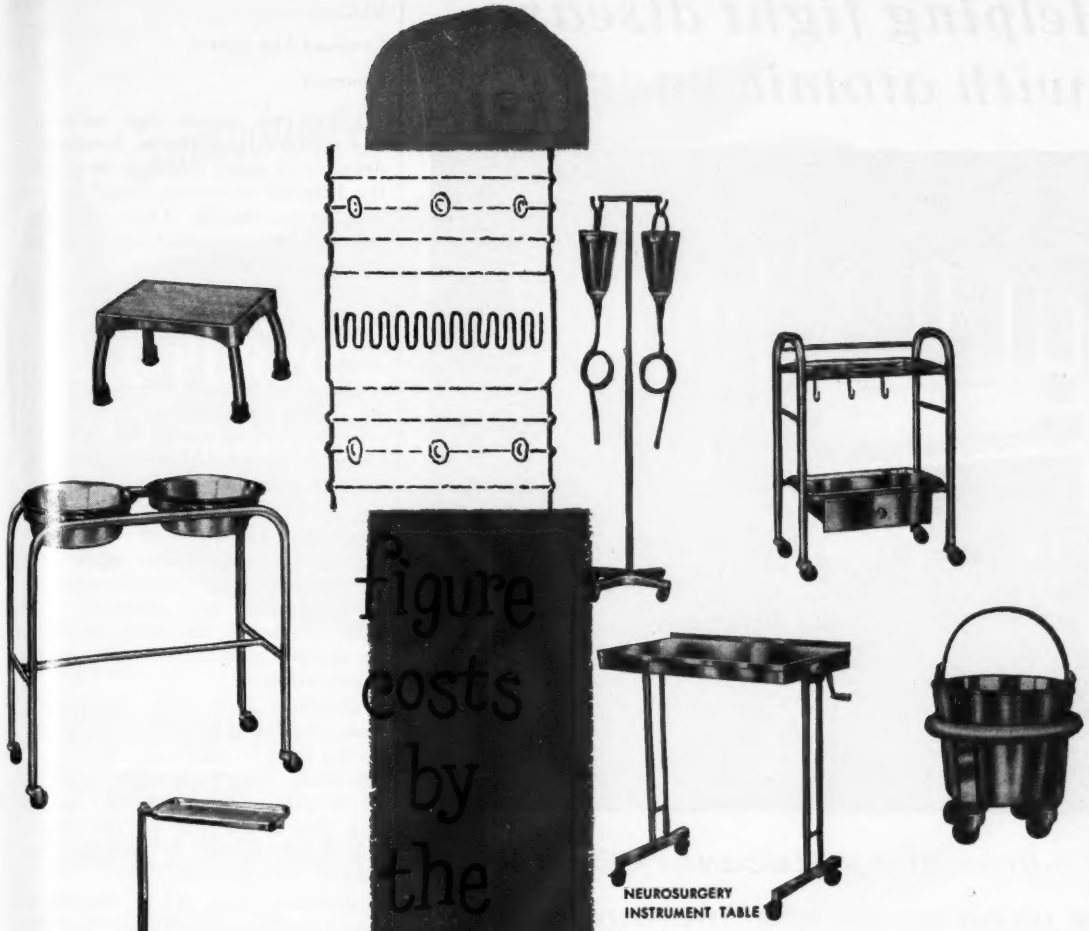
Symposium on Tuberculosis

■ A THREE-DAY international symposium on the status of tuberculosis as a public danger will be held in Philadelphia from Thursday, November 20, through Saturday, November 22, at the Bellevue-Stratford Hotel in Philadelphia, it was announced by Jack Lesser, president of the Deborah tuberculosis Sanatorium and Hospital, Browns Mills, New Jersey.

Chest disease specialists covering every phase of diagnosis and treatment of tuberculosis have been invited from every nation in the world to sit as panel speakers at the symposium.

Dr. George Sommer Jr., chairman of the Symposium Planning Committee, said that among the facets to be discussed are epidemiology, mortality and morbidity changes, case finding programs, bacteriological aspects, prophylaxis including the status of BCG and Isoniazid prophylaxis, surgical aspects of tuberculosis treatment, chemotherapy of tuberculosis, drug resistance, the open negative case and its various implications of public health management.

Dr. Sommer said "The Symposium has been publicly endorsed by the National Tuberculosis Association of the United States." ■



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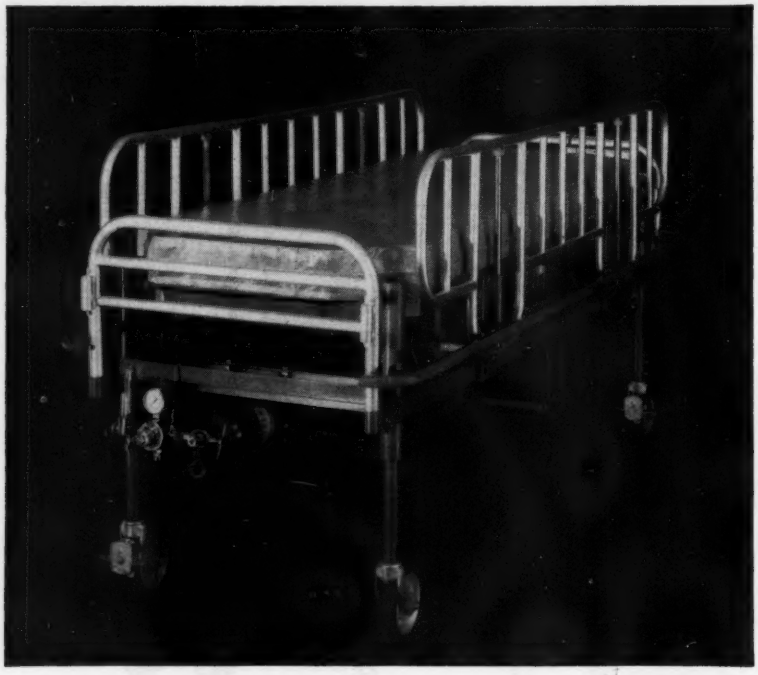

Hill-Rom Hilow Recovery Bed to be used in clinic at International Conference in Switzerland

● Sponsored by the United Nations, the second International Conference on Peaceful Uses of Atomic Energy is to be held in Geneva in September. Patients from central Europe, brought in by doctors from that area, will be examined. In the clinic on Radioisotope Therapy, the new Hill-Rom Hilow Recovery Bed will be used. Doctors who have been using this method of examination have been able to detect tumors in various organs of the body, and those in charge of the clinic are hopeful that eventually it will be possible to isolate a tumor in any area of the body.

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Mittica

Continued from page 7

Summary

1. Can we standardize surgical and medical instruments, bandages, drugs, and other supplies used by the hospital to reduce costs?

Question: Would the medical staffs of our hospitals accept such standardization?

2. The increase in variety and quality of drugs and other patient services has increased costs and deficits.

Question: Should the contributing public be expected to support such services, or should we increase rates of charges in order that we may at least break even?

Question: Should such rates include depreciation of facilities?

3. Some colleges have recognized the desirability of a combination of administration and pharmacy and offer courses at the graduate level in hospital pharmacy and hospital administration.

Question: Does this curriculum encourage the pharmacist to remain in the field of pharmacy, or does it encourage him to go into the field of hospital administration?

4. The availability of the pharmacist in hospitals is controlled by supply and demand.

Question: Does the pharmacy curriculum in our colleges offer the pharmicist sufficient training in hospital pharmacy?

Question: Does the position of part-time hospital pharmacist with additional duties appeal to the pharmacist?

5. While I have not touched upon the free medications gives to indigent patients or special rates for patients using a large supply of medications, this question comes to mind. Should the paying patient be expected to support such an arrangment?

These questions must eventually be answered by the hospital administrator, pharmacist, and medical staff, to the satisfaction of the general public. ■

■ A New York newspaper reporter went up to Maine to interview a centenarian.

He approached the old gentleman, who was sitting on a chair with his cane in his hand, and said, "Sir, you must have seen a great many changes during your 100 years."

The old man replied, "Yes, and I've been against them all." ■

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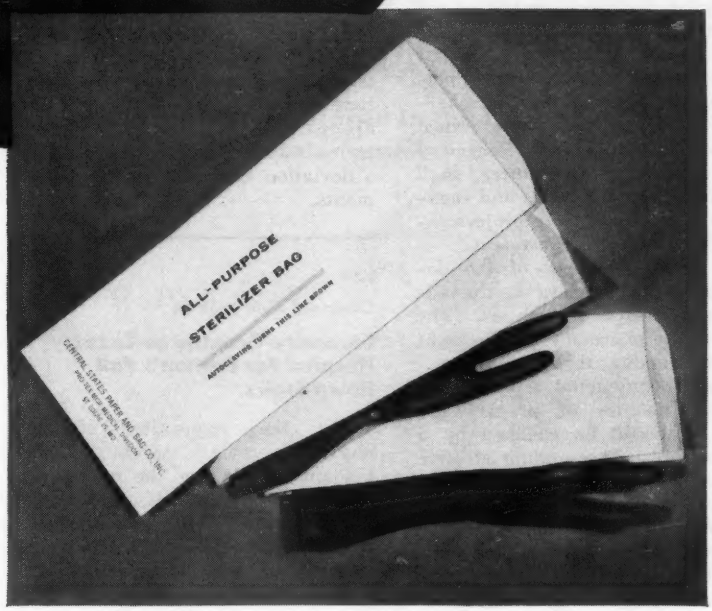

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Lantos

Continued from page 41

ganized pharmacy department under the direction of a professionally competent, legally qualified pharmacist whose training in hospital pharmacy conforms to the standards herein established by the Division of Hospital Pharmacy sponsored by the American Pharmaceutical Association and the American Society of Hospital Pharmacists."

An organizational chart should be prepared showing the various activities and the lines of authority within the department.

Policies should also originate from the Minimum Standard which states:

"The pharmacist in charge, with the approval and cooperation of the director of the hospital, shall initiate and develop rules and regulations pertaining to the administrative policies of the department. The pharmacist in charge, with the approval and cooperation of the Pharmacy and Therapeutics Committee, shall initiate and develop rules and regulations pertaining to the professional policies of the department."

The written policies of the department should relate to the administrative aspects such as, "The hours of the pharmacy will be eight to five Monday through Friday:" and to the functional aspects such as, "All batches of prepackaged products should be checked by a pharmacist." The administrative policies should receive the written approval of the hospital director.

Departmental procedures should be compiled into a procedural manual. This will also be divided into administrative procedures and functional procedures. It may also include specific job descriptions. In preparing such a manual seek the assistance of your pharmacy staff, the Pharmacy and Therapeutics Committee and the hospital director. A coordinated effort such as this will not only provide for a more comprehensive manual, but will also promote a greater understanding and a more rapid acceptance of the manual by those persons who will ultimately share in its use.

A good example of a procedural manual is that used by the U.S. Public Health Service Hospitals. Its director, Dr. George Archambault, in discussing the legal aspects of hospital pharmacy to the Institute on Hospital Law of the American Hospital Association, emphasized that procedural manuals, in addition to the laws, regulations, and Minimum Standards, are becoming tools to be used in law work in applying the degree of standards or the degree of care, below which a hospital might conceivably be found guilty of negligence.[2]

It is important for you to study all of the local, state and federal laws pertaining specifically to your department and make certain that they are being followed. These would include such procedures as the storing and dispensing of narcotics, barbiturates and ethyl alcohol, the storing of all inflammable products, and the refilling of prescriptions. It is your responsibility to call to the attention of the director any policies and procedures which need be instituted or changed, and any physical facilities which need be constructed or altered in order for your department to carry out its legal requirements. It is better to make these changes ahead of time rather than to wait until the fire marshall or the narcotic inspector calls upon the hospitals and finds a deviation from the legal requirements. ■

Law

Continued from page 64

Immunity Granted to Texas Hospital for Patient's Fall Down Stairs

■ At the suggestion of her physician, plaintiff went to defendant hospital for the purpose of having an X-ray taken; she paid a fee of five dollars in advance. Upon inquiry, plaintiff was told the location of the ladies' rest room and she proceeded down the hall according to directions. She opened the door to the rest room and fell because of the higher level of the rest room floor, breaking her leg and hip.

The jury found that the defendant was negligent in maintaining the door to the rest room so as to allow the bottom of the door to extend all the way down to the hall floor; in maintaining the door so as to hide the floor level of the rest room; and in failing to have a sign on the door or otherwise give notice of the condition. Although plaintiff by the exercise of ordinary care could have observed the elevated floor of the rest room, such was not negligence.

On appeal, this court reversed the judgment for plaintiff and held that the trial court erred in overruling defendant's motion for an instructed verdict and in overruling defendant's motion for judgment *non obstante veredicto*, since defendant was a non-profit charitable institution, immune from liability for tort.

(*Baptist Memorial Hospital v. Mc-Tighe, 7 CCH Neg. Cases 2d 14-Tex.*) (*1957*)

Patient Fails to Prove Administration of Drug Caused Gangrenous Condition

■ PLAINTIFF BROUGHT ACTION against defendant-hospital to recover for injuries allegedly sustained because defendant's employees negligently administered an injection. Plaintiff's contended that a drug, Levophed, a stimulant and vasco-constrictor was administered to her subcutaneously rather than intravenously as a result of which she developed a gangrenous condition of the leg. At the close of plaintiff's evidence, the trial court granted defendant's motion for nonsuit, and plaintiff excepted to this ruling. This court held that the evidence showed it was equally probable that plaintiff suffered the injury complained of because of hypersensitivity to the drug even though it was properly administered. The evidence indicated that there was a calculated risk in administering the drug and that it was only used as a last resort when plaintiff's condition was such that doctors were no longer able to get plaintiff's blood pressure. The judgment was affirmed.

(*Camp v. Emory University, 6 CCH Neg. Cases 2d 1327—Ga.*)

Intern's Treatment of Severed Tendon of Child Found Proper

■ THE PLAINTIFF, in January, 1953, the time of the injury, was approximately sixteen months of age and, while playing in her home, fell on a glass bottle which broke and cut her hand severely. The plaintiff was taken by her parents to the Wilmington General Hospital and there treated by an intern then on duty in the emergency ward. At the time of treatment, the plaintiff was crying and struggling so that she had to be held by her parents and a student nurse then on duty.

The intern examined the wound treated it and sewed it up and, in response to a question by the infant's father, stated that the tendons of the hand were not severed. Later, although the testimony is somewhat confused as to the exact time, the

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1. "Standard vs Disposable Unit Enema": Rainier, W. G.: and Lee, B., Hospitals 31:50, Jan. 1, 1957
2. Swinton, N. W., Surg. Clinics No. Am. 35:833, 1955
3. Palmer, E. D., "Clinical Enterology," Hoeber-Harper, 1957

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What Associations Are Doing

Hospital Council of Western Pennsylvania

John T. Ryan

■ AT THE ANNUAL MEETING of the Hospital Council of Western Pennsylvania, held in June, the following officers were elected for a one-year term: Dr. John R. McGibony, president; Mr. Robert J. Dodds, Jr., vice president; Mr. Sidney M. Bergman, treasurer; and Mr. William A. Hacker, secretary.

Mr. Edward V. Graef and Mr. Elmer J. Tropman were elected to three-year terms as members-at-large.

Sister M. Adele, Mr. Leslie J. Reese, and Mr. John T. Ryan, Jr. were elected to three-year terms on the Executive Committee of the Hospital Council of Western Pennsylvania.

A silver tray was presented to John T. Ryan, Jr. "in recognition of outstanding leadership and inspiration in launching an expanded program of hospital coordination for Western Pennsylvania."

Southeastern Society of Hospital Pharmacists

■ JACK KIRKLAND, director of Pharmacy Service, Miners Memorial Hospitals, Williamson, West Virginia, was installed as president at the annual meeting of the Southeastern Society of Hospital Pharmacists in Miami Beach. Going into office for 1958-1959 with president Kirkland were James Mitchener, Cabarrus Memorial Hospital, Concord, North Carolina, vice president; and Perry W. Cox, Carraway Methodist Hospital, Birmingham, Alabama, secretary-treasurer.

At the close of the three-day meeting, the nominating committee recommended the following slate for 1959-1960. For president, Mary Lancaster, Holy Name of Jesus Hospital, Gadsden, Alabama and Gilbert Colina, Mercy Hospital, Charlotte, North Carolina. For vice president, Perry W. Cox, Birmingham, Alabama and Allen Ford, Baptist Memorial, Jacksonville, Florida; for secretary-treasurer, Mary Wernersbach, Mt. Sinai Hospital, Miami Beach, Florida and Howard Clem, Lanier Memorial Hospital, Langdale, Alabama.

St. Louis Blue Cross

■ HOWARD F. BAER, president of A. S. Aloe Company, St. Louis, Missouri, was elected Chairman of the Board of Trustees of the St. Louis Blue Cross Plan.

Hospital Council of Brooklyn

■ THE Hospital Council of Brooklyn, Long Island and Staten Island has elected the following officers for 1958-59: president, Vernon Stutzman; president-elect, Marshall G. Ause; vice president, Kathryn Dooley; secretary, Eva S. Van Dow, M.D.; and treasurer, Seymour Reid.

Honorary Degree of Doctor of Science

■ MAJOR GENERAL LEONARD D. HEATON, commanding general of Walter Reed Army Medical Center, Washington, D. C., has been awarded the honorary degree of Doctor of Science by Denison University, Granville, Ohio.

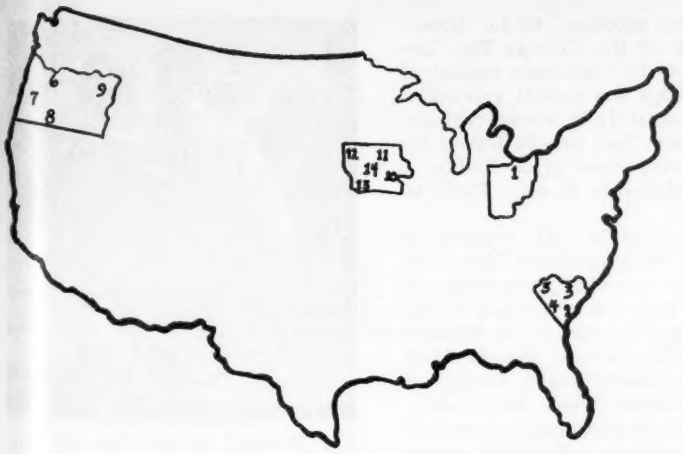
Michigan Hospital Association

■ GEORGE E. CARTMILL, director of Harper Hospital, Detroit, was installed as president of the MHA at the 39th annual convention. Other officers are: A. Kent Schafer, administrator, James Decker Munson Hospital, Traverse City, president-elect; Charles F. Wagg, director, Michigan Department of Mental Health, first vice president; Robert G. Miller, administrator, Bell Memorial Hospital, Ishpeming, second vice president; Vernon T. Root, administrator, Community Hospital, Battle Creek, treasurer.

The Associations highest award, the Gold Key Award for Meritorious Service, was presented to Albert C. Furstenberg, M.D., dean, College of Medicine, University of Michigan, Ann Arbor, "for providing outstanding leaders among the medical staffs of Michigan Hospital," to Joseph R. Homminga, deputy director, Michigan Office of Hospital Survey and Construction, Lansing, "for help Michigan Hospitals to serve their communities more adequately," and to H. Allan Barth, executive director, MHA.

Michigan Hospital Association

■ *Genevieve M. Parker, chief dietitian at Hurley Hospital, Flint, Michigan, accepts the Grand Award plaque in the "Michigan's First Search for New Hospital Achievements" contest from Ralph C. Hutchins, president, left, and H. Allan Barth, executive director, of the MHA at an Award Banquet held during the Association's 39th annual convention at Mackinac Island. In addition to the plaque, Miss Parker received a check for $1,000. The winning entry was submitted by a trio of Hurley workers which also included Katherine Gockel, patient food service supervisor, and Avery Mallison, food service manager, who were unable to be present. Stephen A. Lott, Hurley director, received a plaque for display in the hospital. The contest was sponsored jointly by the MHA and Michigan Blue Cross to elicit ideas which have saved money and improved services in Michigan hospitals.* ■



Fire Safety Institutes, May 1958

1. Lorain, Ohio
2. Charleston, S.C.
3. Florence
4. Columbia
5. Greenville
6. Portland, Ore.
7. Eugene
8. Medford
9. Baker
10. Cedar Rapids, Iowa
11. Mason City
12. Sioux City
13. Council Bluffs
14. Des Moines

Putting Fire Safety on the Map

Lieutenant McGrath has been busy putting out little fires all over the country as the result of a renewed interest in Fire Safety Institutes generated by the fire articles in the January, 1958, issue of Hospital Management.

■ IN FOUR YEARS, from May 1954 to May 1958, the practical fire safety project conceived by Lieutenant Robert McGrath of the Chicago Fire Department, has blanketed the national map from Maine to Texas, from Virginia to California, and most recently from South Carolina to Oregon. Sandwiched in with the latter two, were training trips to Ohio and Iowa.

As a result of Lt. McGrath's article in January HOSPITAL MANAGEMENT,* he says, a number of requests were received suggesting that he conduct fire institutes in various locations during National Hospital Week, May 11 to 17. Naturally, it proved impossible to plan working coast to coast in the space of one week, so the problem was solved by stretching Hospital Week into Hospital Month.

The Lieutenant chose May for his vacation, and opened the long series of institutes at St. Joseph Hospital, in Lorain, Ohio, on May 1 and 2, at the invitation of the administrator, Sister M. Theophane, who is also a member of the American Hospital Association Safety Committee, and is well known for her research in the field of hospital safety.

*HOSPITAL MANAGEMENT, 85: 52-54 (Jan.) 1958.

The following week, which happened to be National CD Alert Week, found him conducting meetings in Charleston, Florence, Columbia and Greenville for the South Carolina Hospital Association. Next, during official Hospital Week, he held training sessions in Portland, Eugene, Medford and Baker under sponsorship of the Oregon Hospital Association.

Sister Mary Christopher, St. Joseph Hospital, Lorain, Ohio, demonstrates that the wrong choice of extinguisher will cause the fire to spread. She is fighting a gasoline fire with a soda-acid extinguisher. A carbon-dioxide extinguisher is correct for a gasoline fire.

From May 19 to 23 inclusive, when the National Fire Protection Association held its annual meeting in Chicago, he worked for the Iowa Hospital Association in Cedar Rapids, Mason City, Sioux City, Council Bluffs and in Des Moines. Co-sponsoring were the Nursing Home, Hotel, Fire Chiefs Associations, and the State Fire Marshal's Office. As part of the publicity promotion, 1,000 reprints of the previously mentioned article were circulated throughout Iowa and adjacent States. This may be a coincidence but, for the first time in any series of institutes, the paid registration in Iowa went over the 1,000 mark. This is a record, to date.

Lt. McGrath now has trained personnel in more than 300 hospitals in 55 cities in 16 states. Institutes have been sponsored by seven State Hospital Associations. They are in

The accompanying text and photos have been compiled respectively by Traian C. Vance, public relations director, St. Joseph Hospital, Lorain, Ohio; James R. Neely, executive director, South Carolina Hospital Association; W. W. Hendrickson, committee general chairman, Oregon Hospital Association; and Lloyd W. Coe, executive director, Iowa Hospital Association.

order: South Dakota, Louisiana, New Hampshire, Maine, South Carolina, Oregon and Iowa. Three more are negotiating, at present.

Ohio

■ THE FIRST FIRE SAFETY INSTITUTE ever conducted in Ohio by Lt. Robert McGrath of the Chicago Fire Department, was held at St. Joseph Hospital in Lorain at the request of Sister M. Theophane, administrator, and Sister M. Adelaide, disaster committee chairman.

Over 400 persons attended the two-day institute from St. Joseph Hospital, from four neighboring hospitals, two civil defense organizations, the Red Cross, the emergency police, the Public Health Nursing Service and the Lorain Fire Department.

Setting the basic groundwork were members of the Lorain Fire Department. The firemen gave instructions on the use of the different types of extinguishers to 615 employees, which is believed to be the largest group ever trained by a fire department.

Oregon

■ LYING ON A BED and covering himself with a blanket of fire presents "no problem" to Lt. Robert McGrath of the Chicago Fire Department. The dramatic subject of fire fighting and patient evacuation leads constantly to unexpected developments, but Lt. McGrath's favorite expression after finding a quick solution is to say, "That's no problem."

Approximately 500 persons in Oregon, Washington and Idaho have a better practical knowledge of dealing with fire as a result of four institutes presented by Lt McGrath and held in Portland, Eugene, Medford and Baker, Oregon, during National Hospital Week, May 11-17.

Under the sponsorship of the Oregon Association of Hospitals, participants included personnel of hospitals, convalescent homes, homes for the aged, civil defense units, public health service and fire departments.

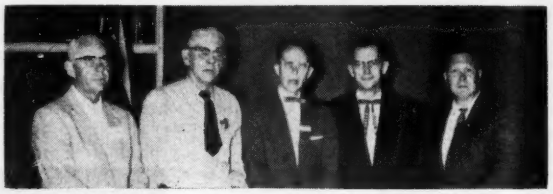
According to Lt. McGrath, drill in a set system of patient evacuation is necessary to avoid confusion, and he advises all hospitals and nursing homes to train personnel in the sequence demonstrated at the class. Once a system is developed, evacuation can be carried out in an orderly manner, he said.

Lt. McGrath's dry wit and abundant energy kept the institutes rolling at a fast pace. Most people are fearful of a fire extinguisher, but he pointed out that since the contents can't hurt you and the noise can't hurt you, the only way you can hurt yourself with this piece of equipment is to drop it on your foot. So there is really "no problem."

The first and largest of the Oregon institutes was held in Portland at the Central fire station, with box lunches brought in at noon.

The Medford nurses drive in with charged hose line on a big fire as instructor McGrath shouts, "Hit it!"

Nurse Persis DeLaMare of St. Vincent Hospital, Portland, learns how to smother fire with a blanket. This hard-to-burn-up patient is Lt. McGrath.



At the Baker Institute the luncheon honored the fire chiefs from the surrounding cities and the following (l. to r.) State Fire Marshall George Kinkaid; Chief Hubert B. Damen, Baker; Administrator Robert A. Paulsen, Pioneer Memorial Hospital, Pineville; President of the Baker Chamber of Commerce; Lt. Robert McGrath, Chicago Fire Department.

This crowd watched a team of four nurses at Eugene go through a complicated drill in 57½ seconds — three patients were evacuated from burning beds, five other miscellaneous blazes were put out and the girls concluded by manning a water hose to douse a wood fire.

Fire in the Medford area looms as a particularly hazardous threat — here the nurses are trained in the use of the fire extinguishers.

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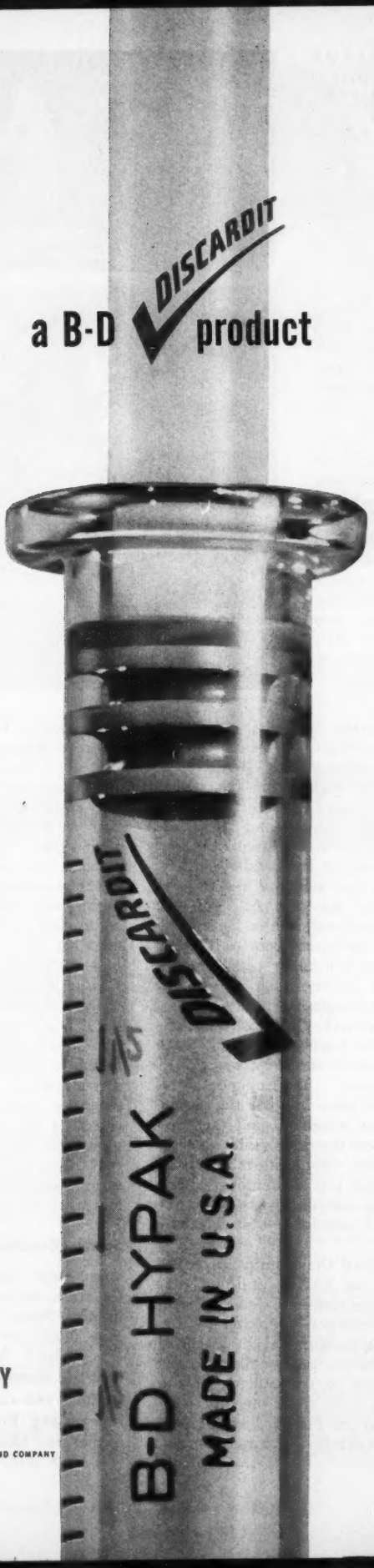

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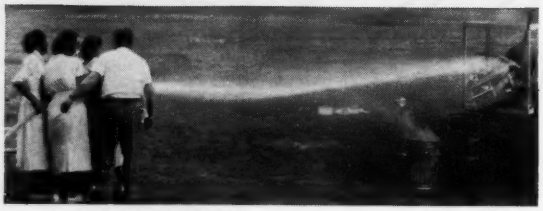
The crowd watches Sister and nurses coordinate first-aid firefighting with the emergency removal of all three R.N.'s enacting patient roles in Florence.

At Charleston the nurses learn how to evacuate even the seriously ill patients.

In Greenville, the patients have been taken care of, all the small fires have been extinguished and now the nurses conclude the drill by walloping a big fire as Lt. McGrath says, "Well done!"



In Columbia through the process of relating nurse and blanket to patient and bed, the fire results in a bit of realism. Nurses react differently to this bit of training. Some say "Oooooooh!" This one, "I do declare!"

A variation in local conditions lent individuality to each setting, but enthusiasm and excitement ran particularly high in Baker where twice the fires leaped out of their planned boundaries and gave the registrants an extra emphatic lesson in bringing fire under control. At Baker, the morning session was held in the Armory. At noon the crowd adjourned to the Hotel Baker for a luncheon honoring the fire chiefs from a number of surrounding cities. After lunch a drill in carrying patients down fire escapes was held outside the local natatorium, and the final session took place in the yard of the Armory.

At Eugene, the Eugene Hotel provided a large hall for the showing of films which opened the program. Since the hall exits directly into a large arena normally used as a parking lot, all demonstrations were held outside, with easy access to the hall for a buffet luncheon.

At Medford the training program began at the YMCA building, situated in the center of the city, and a buffet luncheon prepared by the Sacred Heart Hospital in Medford was served at this location before adjournment to the outside of the Armory, a mile from the city center. Fire in the Medford area looms as a particularly hazardous threat. This part of the country, noted for its fine orchards, was at the time extremely hot and dry by day with the temperature dropping to freezing or below at night necessitating use of smudge pots to save the fruit crops.

Local fire departments at all institutes assisted with personnel and equipment, the maintenance departments of the hospitals in each area set up the many props to provide realism, and Oregon Blue Cross loaned personnel to assist with registration and handle other details of planning. The cooperation of all these groups was a key factor in bringing each institute to a successful conclusion. Excellent coverage was received from the press in all cities. A radio interview with Lt. McGrath was broadcast after one institute, and television coverage appeared after two institutes in news programs.

South Carolina

■ SUMMER COMES EARLY in South Carolina, but all the heat generated in the State during the week of May 5 did not come from the sun. Lt. Robert McGrath figuratively "set the State on fire" with a series of four one-day institutes on Fire Safety and Fire Evacuation Techniques for Hospitals. Not only will the fascination of the institutes be remembered here for a long while, but the interest developed in organizing fire training programs in the hospitals will have an even more lasting effect.

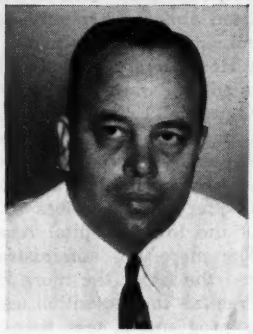
Just as another great conflagration started nearly 100 years ago in Charleston, so did the series of fire institutes in South Carolina begin on May 5. The site was the new Medical College Hospital, almost within view of historic Fort Sumter. Burt Moore, assistant superintendent of the hospital, made all of the local arrangements, including the staging of the outdoor demonstrations on the parade ground at old Porter Military Academy.

The next stop was Florence where planning was under the direction of Ken Gallier, superintendent of the McLeod Infirmary. Although the registrants played tag with rain squalls during the afternoon, the ardor of the participants could not be dampened and the Elks Club Building in Florence housed one of the most enthusiastic audiences in its history.

In South Carolina all roads lead to the State Capitol and all of those roads were used by institute registrants for the third fire institute which was held in Columbia on May 7. The U.S.O. Club Building was the scene of the Columbia institute which was arranged locally by E. P. Barnes, assistant superintendent of Columbia Hospital of Richland County.

Industrial Greenville was host for the last of the four institutes where, with the cooperation of the staff of the Army Reserve Training Center, the largest of the institutes was held. Local planning was done by Cantey Gordon, assistant director of the Greenville General Hospital.

The four institutes drew a total of 524 registrants and spectators. Spectators included primarily student nurses and members of local



DR. L. G. CRANWELL, owner of the Bledsoe Memorial Hospital.

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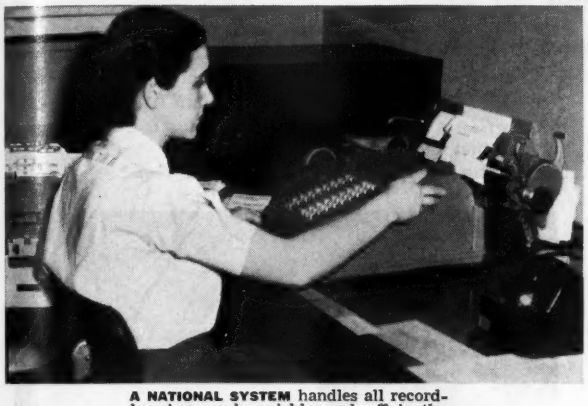

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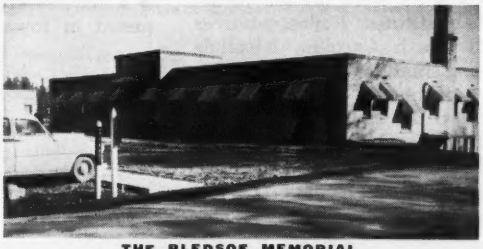

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"Through increased operating efficiency, our National System saves us at least $2,900 a year, pays for itself every 11 months."

L. G. Cranwell

owner of the Bledsoe Memorial Hospital

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fire departments. Broken down by city, the total number of registrants and spectators was as follows: May 5 Charleston 111; May 6 Florence 133; May 7 Columbia 112; May 8 Greenville 168; total 524.

Over-all responsibility for planning the series of institutes was under the direction of Bill Finlayson, chairman of the Council on Civil Defense and Disaster Planning of the South Carolina Hospital Association and administrator of the Conway Hospital, Conway. Numerous other interested groups assisted in promoting the institutes. The State Board of Examination and Registration of Nurses wrote to all of the schools for professional and practical nursing in the state and urged attendance by student nurses. Both the South Carolina Firemen's Association and the South Carolina Fire Chiefs Association promoted attendance among their members.

Through an institute exchange program with the North Carolina Hospital Association, hospitals in North Carolina were invited to attend the institutes. Representatives from 23 North Carolina hospitals plus representatives from a number of fire departments in North Carolina crossed the state line to attend the institutes.

The series of Institutes on Fire Safety and Fire Evacuation Techniques for Hospitals was without question the best attended series of institutes ever held in the State of South Carolina.

In Council Bluffs, the students learn that the swing carry can be used from bed to corridor.

Iowa

■ A SUCCESS STORY that has just happened in Iowa and with the Iowa Hospital Association unfolds like a fairy tale even to the "they lived happily ever after". This story started almost 18 months ago in an administrator's office at the Ottumwa Hospital at Ottumwa, Iowa. In this administrator's hand was a letter from Lt. Robert McGrath of Chicago, Illinois, better known for his comprehensive course of fire drill and hospital evacuation, who had offered his services to District 8 of the Iowa Hospital Association.

The more the administrator perused the letter the more he began to realize the potentialities of this fine program. It was then the administrator made contact with central office of the Iowa Hospital Association and requested that a Fire Drill Institute be explored and carried out.

On June 15, 1957, at a Joint Meeting of the I.H.A. Board of Trustees and the chairmen of the nine program councils, an assignment was made to the Council on Hospital Planning and Plant Operation — "to explore and develop a Fire Drill and Evacuation Institute to be carried out as soon as possible."

This nurse in Cedar Rapids discovers that nurses can carry 40 pounds more than their own weight.

For negotiating close quarters in Cedar Rapids these nurses use the single file method for removing patients.

The stairwells and fire escapes in Cedar Rapids will hold no fear for these nurses who now know how to evacuate a heavy patient.

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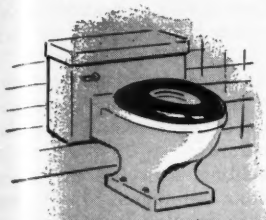

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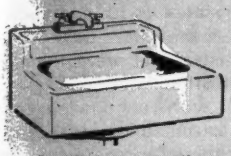
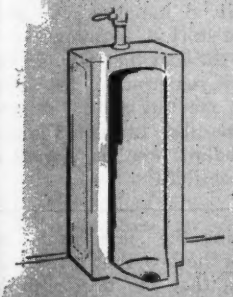
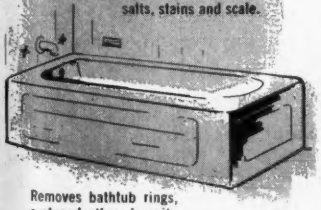


For daily lavatory use. Keeps them both sanitary and clean.



Cleans urinals of ureic acid salts, stains and scale.



Removes bathtub rings, rust and other deposits.

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Use it to replace all work being done by old fashioned cleaners and deodorizers that leave obnoxious fuming odors, and present the danger of poison and skin injury.

Porcena cleans, as it sanitizes, as it deodorizes—just swish it around with the mop and—presto—a new cleanliness you've never known . . . before PORCENA.

- ✓ Removes all traces of Crust, Film, Hardwater scum, Ureic acid salts, Organic matter, Rust, Stains, Lime scale, Germs and Bacteria from tubs, bowls and sinks.
- ✓ Now it's easy to remove the crust under bowl rims that causes odors. Porcena actually works inside the trap.

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The Porcena bottle is a beautiful sculptured design in unbreakable polyethylene. Don't worry when you use Porcena, the bottle can't break...is easy to grip.

THE MOP

A companion to Porcena is this attractive spun porcelon yarn mop. It outwears and holds more liquid than cotton mops. For replacement, just slip off the old head and replace with a new one.

This soft, durable porcelon mop head outlasts cotton mops 5 to 1
Mop head is replaceable and it holds more liquid than cotton
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These Mason City nurses discover that a wastebasket fire can be smothered with newspaper or a blanket.

In Sioux City the registrants take time out between fire training drills to enjoy lunch in the City Auditorium.

At the meeting of this Council on July 1, 1957, basic plans were carried out and Mr. Robert McGrath of Chicago was contacted by the Council. The Council then voted to recommend to the Board of Trustees that the Iowa Hospital Association go ahead.

The Board of Trustees suggested that the recommendation be expanded to include other state-wide groups with similar problems, namely: The Iowa Nursing Home Association, Iowa Hotel Association, Iowa Fire Chief's Association and the State Fire Marshal's Office.

On January 1, 1958, the secretaries of the above groups, acting as the statewide committee, met to decide on (1) selection of area committees (2) mechanics of promotion through the various organizations (3) to assign duties of these committees. Area committee makeup was this: Chairman — Hospital Administrator and a representative from each of the other cooperating organizations.

It was decided that all letters, flyers and other media would originate in the Iowa Hospital Association Central Office and that each association would disseminate it to their memberships.

Duties assigned to the five area committees were simply this: 1) Find appropriate meeting place; 2) Supply necessary props for Lt. McGrath; 3) Supply the food for participants; 4) Aid in the local publicity.

January — announcements in all Association publications.

February — repeat announcement in the above bulletins.

March 15 — repeats of the above.

March 28 — letter to all members of Nursing Home Association, Hotel Association, Fire Chief's Association, State Fire Marshal's Office (for all government agencies). Included in this letter was a reprint of Robert McGrath's article* from *Hospital Management* magazine.

April 10 — Beginning of the newspaper, radio and TV news releases. These releases to be sent every week to all Iowa daily and weekly papers plus the local radio and TV stations.

April 19 — Memorandum (done on red paper) to all members of the above Associations including tentative program and registration blanks.

May 1 — A last appeal letter (done in red printing on white paper) plus a registration blank for late registrants.

The mailing lists for the other Associations numbered 1,200 plus the mailing list that was developed for the 100 hospitals in the surrounding states (within a radius of 100 miles of the state line).

All registrations were done on a pre-registration basis and all were answered with acknowledgements.

It was a tremendous task, but the results of the effort more than justified what we had set out to do.

"They lived happily ever after" part of the story is as follows:

Despite the fact that we had been told a $5 registration fee would cause our meeting to be a failure because in other states $3 seemed to be standard, we had a total attendance of 1,004. ■

*HOSPITAL MANAGEMENT, 85: 52-54 (Jan.) 1958.

Law

Continued from page 80

plaintiff was again taken to the defendant hospital. This subsequent visit was either four or ten days following the accident. She was again examined by the same intern who noted that a stiffness had developed in the index finger of her right hand. At this time the intern did not diagnose the stiffness as having been caused by a severed tendon, although, again on this point, the testimony is confused.

In this case the plaintiff attempted to establish the standard which should have been complied with. This was done by the testimony of two admitted experts in the field of treatment of injuries of this nature. It is clear from their testimony that it was entirely possible in examining this patient according to that standard not to ascertain at the time of such examination that a tendon had been severed. It is furthermore clear that the failure to ascertain immediately the severing of the tendon did not result from a failure to conform to the accepted standard and, in any event, that no permanent injury has followed the failure to discover the condition.

It seems clear from the plaintiff's case that the intern at the defendant hospital examined the infant plaintiff as any other doctor in the community would have examined her under like circumstances. There is no evidence that his treatment of the wound and suturing failed in any respect to conform to the established standards for the medical profession.

This being the state of the evidence it is the law that a presumption arises that the doctor in fact exercised ordinary and reasonable care and prudence in the treatment of the wound, when there is no direct evidence to the contrary.

The judgment of dismissal of the complaint was affirmed.

(Christian v. Wilmington General Hospital, 7 CCH Neg. Cases 2d 687-Def.) (1957)

■ THERE IS GOOD in all things and in all people, but it has to be sought and understood. When you learn to see this basic goodness, and when it becomes more important to you than superficial appearances, only then will your viewpoint change. ■ —B. E. Sturtevant in *Good Business.*

A.C.H.A. Activities

NEWS and VIEWS from the American College of Hospital Administrators

Members of the College who are participating in the Group Insurance Plan have been notified that they will receive a 20 percent dividend for the policy year ending February 1, 1958.

Announcement was made by Dean Conley, executive director on behalf of ACHA Group Insurance Plan.

The program was established early in 1955 upon the recommendation of the Insurance Committee and with the approval of the Board of Regents. The plan is expressly for members of the College.

The first session of the Book Award Committee of the College was held last month during the annual meeting under the direction of chairman James A. Hamilton, director, Hospital Administration, University of Minnesota.

This committee has the responsibility of selecting an outstanding book on the administrative process for formal commendation at the College's Second Annual Congress on Administration in February, 1959.

According to Chairman Hamilton, the committee reviewed the ground rules for the selection and gave consideration to various aspects of the annual book award competition.

Last year, the committee named Herbert A. Simon's book, *Administrative Behavior,* as the outstanding work of its choice. At the first Congress on Administration, Professor Simon, a member of the faculty of the Carnegie Institute of Technology was awarded a $500 cash prize and a medallion.

Dr. Charles U. Letourneau, editor of *Hospital Management* and director of the Course in Hospital Administration at Northwestern University is one of the new members of the Book Award Committee.

Other committee members are Col. Frederick H. Gibbs, director, Inter-agency Institute, Washington, D.C.; James A. Lorie, Ph.D., associate dean, Graduate School of Business, University of Chicago; Herluf V. Olsen, Ph.D., Ames Tuck School of Business Administration, Dartmouth College, Hanover, New Hampshire; and Edward Watson, Ph.D., School of Business, Northwestern University, Evanston, Illinois.

The winner of the Book Award competition of the College will address members at the Second Annual Congress on Administration, scheduled for February 5-7 at the Hotel Sherman in Chicago.

Two Regional Members Conferences will be presented by the College next month in Regions 10 and 11.

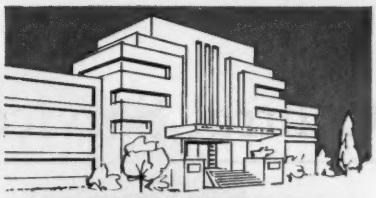
The first conference is scheduled for Region 11, which includes Missouri, Arkansas, Nebraska, Kansas and Oklahoma, will be held at the Muehlebach Hotel in Kansas City. Bryce L. Twitty, administrator of the Hillcrest Medical Center in Tulsa, is the Regent for the region.

The Second Regional Members Conference will be held at the Curtis Hotel in Minneapolis, Minnesota, between October 27-31. This conference will be directed by Robert W. Bachmeyer, Regent for region 10, an area consisting of Minnesota, North and South Dakota and Iowa.

Regent Bachmeyer is director of St. Barnabas Hospital in Minneapolis

Regional Members Conferences are offered for members of the College and include a varied program on hospital administration.

The final institutes of 1958 will be held in Dallas, Texas. December 1-5. It is the first Southwestern Advanced Institute and it will be held on the campus of Baylor University. ■



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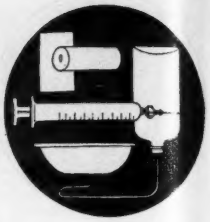
Central Service



by Mary Helen Anderson, R.N.

Is Central Service Supervision Nursing?

■ THE ANSWER TO THIS QUESTION must wait until there has been developed a satisfactory definition of nursing itself. We may just as well ask, "Is care of the newborn nursing?" Or, "Is handling office routines of a practicing physician nursing?" Or many of the now developed specialties in the profession.

Much has been said to answer the question in reverse, "Is a central service supervisor necessarily a nurse?" It would seem reasonable to expect that when the first question is answered, the second will lose its significance. As yet, there is much to be said both ways.

The following letters, the first received by the C. S. Editor and the second, the reply, are almost self-explanatory. They are reproduced here to illustrate current thinking on the subject.

"Dear Miss Anderson:

The Interstate Central Service Association is composed of nurse personnel from about 20 hospitals covering an area of nearly 100 miles in Washington and Oregon. Most of our members are avid readers of HOSPITAL MANAGEMENT and, of course, are particularly interested in the Central Service section. At least two of us know you by association — one from meeting you at the Chicago C. S. Institute in 1954, and one from the Institute held in Los Angeles in 1955. It is because of your reputation of diligent effort toward the furthering of unity and prestige of the Central Service departments of our representative hospitals that this letter is prompted.

"This effort was exemplified in the article appearing in the November 1957 issue titled, *'Central Service Personnel at the International College of Surgeons.'* Yet in direct contrast is the featured article in the December 1957 issue, concerned with *'The Pharmacist as Central Service Supervisor.'*

"We feel strongly that in writing this article you have lost faith with your profession. We are not ready to admit that the pharmacist is a logical person to step in and take over the reigns of this department that has nurtured through the era of growing pains by the professional nurse. Nor do we feel that the pharmacist, nor any one of the other allied hospital personnel who were mentioned, could do the job better. We do not feel that the arrangement suggesting that a pharmacist assume the administrative supervisory responsibility with 'a registered nurse reporting to him' or 'utilizing consultation services of one or two graduate nurses' will reduce personnel expense or 'release a professional nurse for the more vital function of direct patient care.' In the present staffing arrangement, few hospitals have more than one or two nurses in Central Service.

"Who is in a better position than the professional nurse to bind together the activities and principles of Central Service to the larger responsibility of direct patient care? Who is in a better position to be the emissary for nursing service in the selection of supplies and equipment than the nurse who has undoubtedly spent much time doing bedside nursing before her appointment to Central Service?

"It is mentioned that one of the advantages of the pharmacist in this post would be 'making use of his skilled training in the procurement of drugs and chemicals and his knowledge of specifications and quality standards in buying supplies for Central Service.' Is it not equally advantageous to maintain the nurse in this position who, by virtue of her bedside nursing experience possesses intimate knowledge of the adaptability of certain supplies and equipment to patient care? And is not the more formal aspect of buying the *specific* function of the purchasing agent?

"If the statements set forth in this article are not yours, but only the documentation of a trend or a given situation, you have failed to use your editorial prerogative to speak of the worth of the RN in this same situation. Certainly the organized

Please turn to page 119

National Association of Hospital Central Service Personnel NOTES

■ APPLICATIONS have been coming in to fill the ranks of charter membership. We are still interested in hearing from local groups — regardless of how informal the organization — that are meeting to discuss Central Service problems.

Central Service personnel in the Chicago, Illinois, area will be having the first big meeting in September. Central Service supervisors in the state of Illinois who have not received information about the meeting, inquire of the C. S. National secretary, Miss Wilma Leppert, West Side Veteran's Hospital, Chicago, Illinois.

The executive committee of the NAHCSP announces a contest for an official symbol or emblem of the association to be used on the official printed matter as well as on the membership certificates. The competition is open to anyone engaged in Central Service work, and entries may be sent to the office of the secretary, Miss Wilma Leppert, whose address is given above. The contest will close on December 31, 1958, and the winner will be presented to the membership at the annual meeting in May of 1959. ■

Where Do Great Ideas Come From?

From its beginnings this nation has been guided by great ideas.

The men who hammered out the Constitution and the Bill of Rights were thinkers—men of vision—the best educated men of their day. And every major advance in our civilization since that time has come from minds *equipped by education* to create great ideas and put them into action.

So, at the very core of our progress is the college classroom. It is there that the imagination of young men and women gains the intellectual discipline that turns it to useful thinking. It is there that the great ideas of the future will be born.

That is why the present tasks of our colleges and universities are of vital concern to *every* American. These institutions are doing their utmost to raise their teaching standards, to meet the steadily rising pressure for enrollment, and provide the healthy educational climate in which great ideas may flourish.

They need the help of all who love freedom, all who hope for continued progress in science, in statesmanship, in the better things of life. And they need it *now!*

If you want to know what the college crisis means to you, write for a free booklet to: HIGHER EDUCATION, Box 36, Times Square Station, New York 36, N.Y.

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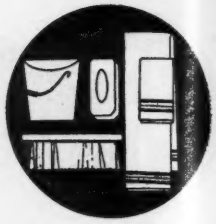

Cost Control System

by Emma Morgan

■ THE HOUSEKEEPER should be ever conscious of costs in her department. Budgets are kept in all hospitals and it is essential to know the amount of money needed to run an efficient department. Therefore, it is necessary to keep complete records but, because the housekeeper usually does not have adequate office help, the records must be simple to maintain.

The system explained in this article is easy to keep and yet is adequate as a base for your budget requests for the next year.

Price By Unit

The first column (table 1) marked "unit cost" is the price that the housekeeping department has to pay for each of the items listed. The cost of some supplies will be by the dozen, some by the carton, some by each. It is easier to figure the amount for each article (each cake of soap and each roll of toilet paper) because when the supplies are distributed to the units, they are given out by the roll in the case of toilet paper, and by the cake in the case of soap.

Each day the amount of supplies given out are recorded in the proper column on the monthly form which indicates the days of the month across the top and the individual items down the left side. This day-to-day comparison will reveal which item is used most often, which floor uses the most and which unit has a sudden increase of use of items.

These records are kept on file so that a complete total can be taken at the end of the year. It shows how much of each item has been used for the year and is a guide as to the probable amount needed for the coming year. Therefore, it is easy to estimate the amount needed in the budget for supplies.

Cost of Man-Hours

It is also necessary to learn how how much it costs to clean the hospital and a record should be kept of the cost of man-hours. If workers are spending part of their time in two or three places a daily record can be kept as indicated in table 2. Each worker works five days a week. This record will reveal the amount of money being spent in cleaning each area, but it should be studied carefully by the executive housekeeper to see if the proper amount of time is being spent in the most important areas. ■

Table 1. Amount of Housekeeping Supplies Used, Cost per Unit, and Total Five-Day Cost

Unit Cost	Item	Used Day 1	Used Day 2	Used Day 3	Used Day 4	Used Day 5	Total Used	Total Cost
0.04 ea.	Soap	15	10	10	15	10	60	$ 2.40
0.11 ea.	Paper Towels	10	12	10	20	10	62	6.82
0.07 ea.	Toilet Paper	6	6	6	8	6	32	2.24
2.00 gal.	Wax	1	0	0	0	0	1	2.00
1.00 qt.	Furn. Polish	1	0	0	0	1	2	2.00
0.50 ea.	Mop heads	2	0	0	2	0	4	2.00
0.75 ea.	Corn broom	1	0	0	0	1	2	1.50
	Cost of supplies used in five-day period							$18.96

Table 2. Departmental Distribution of Hours and Salary of Housekeeping Personnel

Name	Salary per hour	To Clinic	To Surgery	To Animals	To Laboratory	To Office	To Medicine	Doctor's Home
John	$1.25	4-$5.00	4-$5.00					
Joe	1.25			2-$2.50	6-$7.50			
William	1.25					3-$3.75	5-$6.25	
Mary	1.00					2-$2.00	6-$6.00	
Helen	1.00	4-$4.00						4-$4.00
Ann	1.00		8-$8.00					
Daily Cost of Each Department		$9.00	$13.00	$2.50	$7.50	$5.75	$12.25	$4.00

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Like all *Finnell Fast-Acting Cleansers, Sanax* is specially designed for the greater speed of machine-scrubbing, and works as effectually in a *Combination Scrubber-Vac* as in a *Conventional Scrubber-Polisher.* And because *Sanax* is processed from pure vegetable oils, it's *safe for all floors.*

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Building Maintenance

Economical Operation and Installation of Air Conditioning Systems in Today's Hospitals Must Consider Operating and Maintenance Requirements as Related to Cost of Patient Care

Air Conditioning System Types and Related Problems

by Daniel Roop

■ THE PHYSIOLOGICAL PRINCIPLES of ventilation and air conditioning should first be defined so that a clear concept of the attempts to design, install and operate an air conditioning system in proposed or existing hospital buildings can be fully understood.

Ventilation is defined in part according to the *Guide On Heating, Ventilating and Air Conditioning,* published by the American Society of Heating and Air Conditioning Engineers, as *"The process of supplying air to or removing air from any space by natural or mechanical means."* In consideration of this statement, we must be aware of not only the quantity of air, but also the quality.

Air conditioning in its broadest sense implies control of any or all of the physical or chemical qualities of the air about us. Air conditioning may be defined, *"As the process by which simultaneously the temperature, moisture content, movement and quality of the air in enclosed spaces intended for human occupancy may be maintained within required limits. If an installation cannot perform all of these functions, it shall be designated by a name that describes only the function or functions performed".*[1]

Six Types of Systems

When we in hospitals today speak of air conditioning, there are basically six types of systems that may be considered. These are:

1. Window units
2. Self-contained or "packaged" units
3. Central plant systems, as follows:
   - A. Zone system, air handling units, low velocity
   - B. Individual fan coil units in patient's room
   - C. High velocity—conduit induction coil system; double duct system

One of these should be considered as the best type of system suited to the geographical location of the hospital and the operating and maintenance problems that will be faced by the hospital over a long period of amortization.

Criteria for Analyzing System

Simultaneously with the six types of air conditioning systems that have just been mentioned, there are also six criteria that generally should be followed in properly analyzing these system types:

1. Suitable air temperatures must be automatically controlled to meet varying load conditions within a zone area, as well as private patients' rooms and departmental space. This control should automatically adjust for varying population; changes in outdoor temperature (both dry bulb temperature and wet bulb temperature); sun load; prevailing wind direction; and other factors.
2. A control of 45 to 50 percent of relative humidity must remain at all dry bulb temperatures.
3. Adequate conditioned air, consisting of a mixture of outdoor air (minimum desirable 25 percent) and recirculated air, must be circulated to accomplish the above and to provide the right amount of air motion.
4. Objectionable dust, smog, and odors must be removed from the air supply through proper filtration.
5. Outdoor air, cooled and dehumidified in the summer, must be introduced at such a rate that odors are prevented and the fouling of coils is avoided.
6. Extraction of air from all rooms so as to remove smoke, odors, heat, and other objectionable constituents.

Air Conditioning in Hospitals

Why provide air conditioning at all in the hospitals of today? It provides top employee efficiency resulting in better patient care. This statement has been substantiated in recent months through figures compiled and published as a result of a national survey. Air conditioning aids in patient recovery, resulting in a shorter stay, in turn releasing beds for other patients. This is of vital importance in areas where hospital needs are critical.

Air conditioning in today's hospitals is becoming increasingly important and is considered by many to be as basic a requirement as was a good heating and ventilating system several years ago. *But,* advisability of central plant air conditioning must be studied in relation to the geographical location of each

[1] A.S.H.V.E. Code of Minimum Requirements For Comfort Air Conditioning.

hospital plant. Central air conditioning or any type of air conditioning for an entire hospital facility cannot be justified in all geographical locations. Considerations of the number of days of uncomfortable weather conditions, studying such factors as wet bulb and dry bulb temperatures, can easily provide an owner with factual information as to the advisability of complete hospital plant air conditioning.

The types of systems, as previously mentioned, are outlined in table 1. A brief explanation of some of the major points resulting in the rating factors as shown in table 1 will be discussed.

For enumerating some of the problems related to these various types of systems, the owner, who is considering air conditioning in any form, must pay particular attention to operation, function, and desired conditions required in all areas of the hospital. Think briefly for a moment of the number of departments that are in your hospital. Each one of these departments (such as dietary, surgery, administration, engineering, radiology, pathology, business office, physical therapy, pharmacy, and others) requires different space temperature conditions. This tends to make our hospital air conditioning plant much more intricate and complicated than those of office buildings and commercial facilities where occupancy and services performed are common to all occupants.

Basic standards for some of these systems will be found in the following publications: *American Society of Heating and Air Conditioning Guide,* 1958; National Fire Protection Association Bulletin 90A, titled *Standard For the Installation of Air Conditioning and Ventilating Systems of Other Than Resident Type;* and N.F.P.A. Bulletin 56, titled *Recommended Safe Practice for Hospital Operating Rooms.*

The inability of many types of air conditioning systems installed today to perform in accordance with the desires of the owners are based on the lack of knowledge and ignorance on the part of the designing engineers and architects to fully understand and have cognizance of the functional problems of the hospital's various departments. This statement is merely made to point out the need for the design engineer and architect to learn specifically all that he probably can regarding these functions and specific load characteristics of the various departments and areas within the hospital structure.

As an example: Does he realize that at a nurses' station and workroom area the following people are employed?: nurses aides; student nurses; nurses; floor secretaries; doctors; and residents. Does he also realize that the following equipment is going to be installed in this area?: electronic devices, ice machines, domestic refrigeration, instrument sterilizers, and in some instances an occasional use of open hot plate of either electric or gas design. All of the personnel and equipment in this general area produce heat. This heat must be dispelled through proper air conditioning. The owner, architect, and the design engineer must be cognizant of these problems.

Does the owner-architect-engineer team realize that a greater volume of fresh air will be required in pathological laboratories than will be required in business offices? Can we justifiably put both patient rooms and laboratories on the same air supply system and expect to have properly air conditioned spaces?

This team should recognize that

Please turn to page 105

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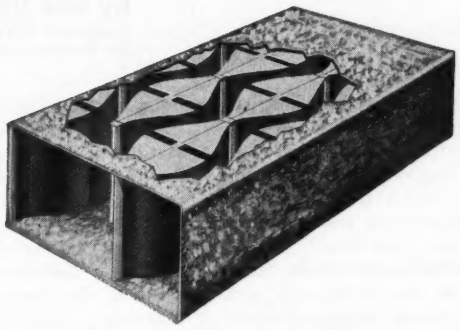

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A DIETARY BAEDEKER

A Peek Through The Tray Assembly Looking Glass

by Leo Dardarian
Consultant in Food Service
San Francisco, California

■ NO FUNCTION of the hospital kitchen is more central or crucial than the putting together of patients' trays. The collective group of processes by which this is accomplished is called tray assembly or, more familiarly, "tray line."

In most kitchens, the words "tray line" serve as the battle cry and well-trained troops storm to their stations and stand in dread poise through the fateful moments before the charge. The first tray down the line sounds the alarm, and tray by tray the valiant troops battle bravely to a man until, seemingly ages later, the peak is passed—and the valiant troops, limp and spent, drag quietly away.

Not all kitchen tray assemblies take such a human toll, but many do and therein this narrative finds its audience.

Assembly Time vs. Idle Time

An examination of the tray assembly process is certainly in order since tray assembly times constitute the peak periods of kitchen activity during the day. Obviously, any improvement in this function will significantly effect the entire operation.

Assembling trays is just like any other assembly line or chain step process in that each successive operation is dependent upon the previous one. If any step of the process is poorly handled, the entire production will suffer.

Each station of the assembly line must produce at the same rate of speed, otherwise the subsequent stations will have nothing to do and, for lack of something to work on, they remain idle. Any assembly line must be judged not only on the basis of its production, but also upon the amount of *idle time* the setup of the line produces. In manufacturing, labor and management continually work for a uniform distribution of work along the stations of a line, so that production will flow smoothly and no station will be over-taxed or under-burdened.

Uniform Distribution of Work

Similarly, a good tray line must be judged by the degree to which work is uniformly distributed along the stations of the line. To make this judgment, check each station of the line (with a stop watch if one is available) to determine how much time is spent working and how much time is spent waiting. If there are large variances between work time and wait time from station to station, obviously a redistribution of tasks is in order.

The average tray might have between 20 and 40 items, counting all the china, silver, paper, food and condiments. Multiplying the number of items by the number of trays will give an approximate count of the number of operations to be performed (this won't take into account all the secondary operations; like getting another tray of salads or stack of dishes).

If the hospital requires 100 trays, then some 3,000 primary operations will have to be performed. If there are eight people working the assembly line, each of them will perform approximately 375 operations. Naturally, all of the operations are not the same; some are a simple reach and place and others require some selection or addition before being placed on the tray. Similarly, the time required for each of the operations will vary. As far as possible, the amount of work each person has to do to each tray should be the same as each other person has to do, and should be the same from tray to tray.

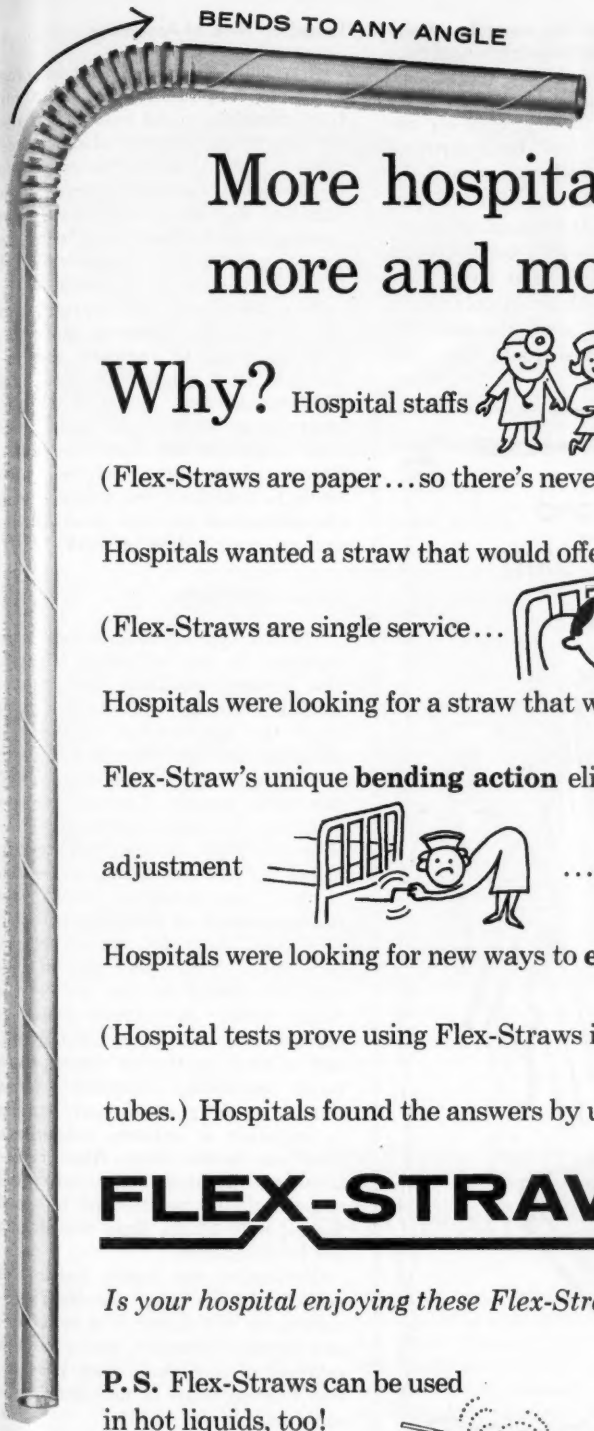
Speed of Assembly

One statement frequently heard regarding tray assembly is "*Oh, our tray line is very good. We do 250 trays in an hour*", indicating that speed is a measure of the good tray line. Unless the time required for assembly goes beyond the normal meal period, it is not felt that speed, for its own sake, is an essential attribute of the "*good*" tray line.

From a logical standpoint, the reverse is true. It is practically an axiom of business that management should attempt to spread the peak periods of the operation over the longest possible period. This is necessary for a number of reasons, the most important being the high cost of staffing a brief peak period.

Let's look at it another way.

The speed of a tray assembly line



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depends upon several factors. First, the number of *operations* (the number of items per tray times the number of trays). Second, the number of *hands* or people performing the operations. And third, the *physical design* of the facility, the arrangement of the *individual work stations*, et cetera.

Take the example given previously, where 100 trays of 30 items each constituted a work load of 3,000 operations. If five people handle the assembly, they must perform 600 operations each; ten people must handle 300 each. If the average time per operation is ten seconds, in the first instance, the assembly will take 100 minutes and, in the second, the assembly will take 50 minutes. By improving the facility used for assembling trays and by improving the individual work station and the manner in which the work is distributed, it might be possible to reduce the average time per operation to six seconds. In that case, then, the assembly with ten people would take 30 minutes, while the assembly with five persons would take one hour.

Lengthen Time of Assembly

It appears, therefore, that in some instances lengthening the time for tray assembly might result in a reduction of the number of hands required. Also, it might be advisable to assemble the basic tray, with only the service items, between meal periods because, in effect, this would constitute a lengthening of the peak period in the kitchen.

This discussion, of course, does not reduce the necessity for constantly trying to improve the individual work station and the total assembly process. A continual aim must be to reduce the amount of time required for each operation. Continued attempts also must be made to distribute the items among the stations of the line to achieve a uniform distribution of work.

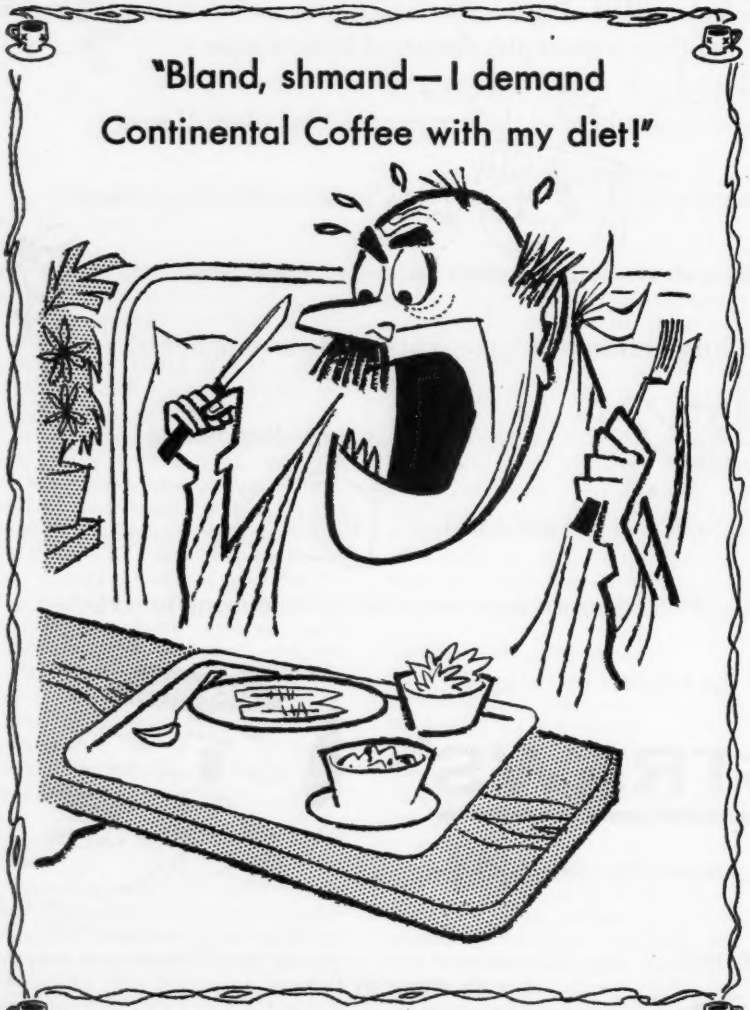
Special Diet Items

Frequently, special diet items are assigned to an individual station. The person working this station generally stands with arms folded while the regular diet trays move along the line and then has to work at a furious pace when the special diet trays appear. A simple way to evaluate this more clearly might be to make a list of the items to be placed on the tray. Then, after each of the items, make an estimate of the percentage of trays upon which that item must be placed. Knife, fork, spoon, tray cover, napkin, for example would be 100 percent items; coffee, 85 percent; soup, 40 percent; salt and pepper, 90 percent, and so on down the list. Based upon these percentage estimates, items should be assigned to each station to maintain a uniform percentage from one to the other. After redistributing the items, the individual stations should be checked to see if the amount of idle time per station has been reduced.

Obviously, the exact nature of each hospital's tray assembly circumstance will differ to a considerable extent. However, the principles relative to any chain-step production process must of necessity have some application to all. ■

The dietitian who endeavors to work not only with the doctor and nurse but with other disciplines such as Social Service can extend herself and her professional help all the way into the home and community.

—Miss Margaret N. Hinkle, dietitian, Columbus Receiving Hospital, Columbus, Ohio.



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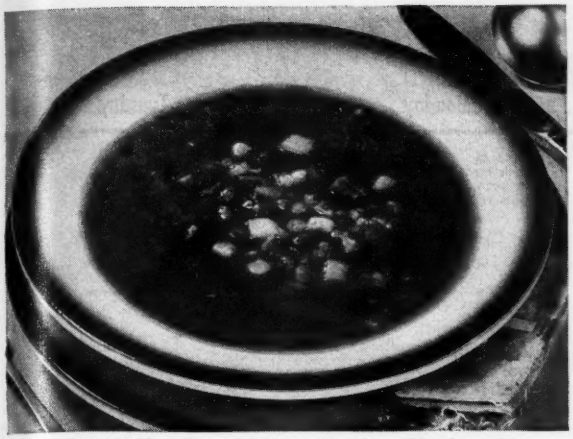

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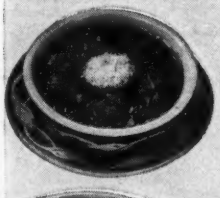
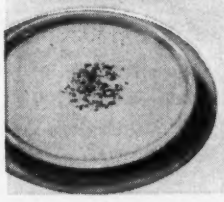


Sexton French Style Onion Soup Mix combines the flavor of selected onions simmered in fine beef stock. A case makes 256 six ounce cups of French Onion Soup for less than 4c per cup.



Sexton Potato Soup Mix. For tasty potato soup add the mix to water and cooked diced potatoes. Cost: Less than 5c for a large 8 oz. serving. For a richer "hot vichyssoise" type soup, use whole milk.

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Monthly Menus

	Sunday	Monday	Tuesday
Breakfast	1 Bananas in cream Hot or ready to eat cereal Shirred egg Toast croutons	2 Kadota figs Hot or ready to eat cereal Three minute egg Raisin toast	3 Tomato juice Hot or ready to eat cereal Oven French toast Jelly
Dinner	Stuffed pork roast Potato cakes Spinach a la Swiss Mexican salad Apple torte	Grilled liver and bacon Pittsburgh potatoes Creole celery Carrot raisin salad Chilled fruit cup	Braised beef and noodles Stewed tomatoes Vegetable relish salad Peach ice cream
Supper	Bouillon Spaghetti with tomato meat sauce French green beans Golden glow salad Nabiscoes	Cream of vegetable soup Savory meat loaf with mushrooms Corn a la Southern Apple salad - lime dressing Cream puffs	Alphabet soup Hot chicken sandwich Lattice potatoes Celery curls - olives Raspberry bavarian cream
Breakfast	8 Baked rhubarb Hot or ready to eat cereal Three minute egg Toast	9 Pineapple juice Hot or ready to eat cereal Pancakes Syrup	10 Fresh grapes Hot or ready to eat cereal Omelet Raisin toast
Dinner	Broiled lamb pattie Mashed potatoes Baby lima beans Pineapple ring salad Fluffy peach pudding	Boiling beef - horseradish sauce Potatoes in jackets Turnip greens Banana nut salad Cherry cobbler	Ham Hawaiian Delicious sweet potatoes Frozen peas Tossed salad greens Baked apples
Supper	Clear tomato soup Frizzled beef on corn timbales Hot slaw Fruit layer salad Oatmeal macaroons	Pepperpot soup Canadian bacon Delmonico potatoes Tomato escarole salad Jelly roll	Cream of celery soup Braised short ribs of beef Hash brown potatoes Fruited gelatine salad Chocolate fudge pudding
Breakfast	15 Orange half Hot or ready to eat cereal French toast Syrup	16 Purple plums Hot or ready to eat cereal Three minute egg Toast	17 Cinnamon applesauce Hot or ready to eat cereal Scrambled eggs Cherry kolaci
Dinner	Roast leg of veal Golden brown potatoes Green beans Endive tomato salad Coconut cream cake	Minted fillet of lamb Riced potatoes Sauteed eggplant Citrus fruit salad Bread pudding deluxe	Yankee pot roast Lyonnaised potatoes Cauliflower Krispy relishes Orange sherbet
Supper	Mushroom bisque Pork tenderloin Duchess potatoes Waldorf date salad Frosted doughnuts	Spanish bean soup Stuffed green peppers Corn pudding Garden salad Fresh pear halves	Noodle soup Chicken a la King on toast points Buttered peas Frozen fruit salad Iced graham crackers
Breakfast	22 Grapefruit half Hot or ready to eat cereal Three minute egg Toast	23 Tomato juice Hot or ready to eat cereal Shirred egg Toast	24 Bananas in cream Hot or ready to eat cereal Canadian bacon Toast
Dinner	Salisbury steak Watercress potatoes Swiss chard Pear-a-dise salad Fruit whip	Roast fresh ham Potato cakes Succotash Fiesta salad Apple pan dowdy	Veal steak - Parmesan Baked yams Breaded tomatoes Dill pickles - sliced carrots Grapenut pudding
Supper	Oxtail soup Cold luncheon meats Baked beans Fruited cheese ball salad Chocolate nut brownies	Jellied consomme Lamb stew Cauliflower salad Hot rolls - preserves Sliced peaches in cream	Swiss potato soup Barbecued beef on buns Perfection salad Burnt sugar cakes
Breakfast	29 Fresh grapes Hot or ready to eat cereal Creamed chipped beef on toast	30 Prunicot Hot or ready to eat cereal Broiled link sausage Cinnamon rolls	
Dinner	Beef pattie-tomato sauce Baked sweet potato Diced turnips Lettuce wedge - French dressing Orange frosted gingerbread	Swiss steak Scalloped potatoes Green lima beans Cabbage slaw Spicy cherry torte	
Supper	Vegetable soup Barbecued beef sandwich Perfection salad Peach flummery	Cream of celery soup Fruit salad plate with cottage cheese Nut bread sandwiches Chocolate chip ice cream	

...September 1958

Wednesday	Thursday	Friday	Saturday
4 Grapefruit half Hot or ready to eat cereal Crisp bacon Cinnamon bun • Breaded veal cutlet Mashed potatoes Baked Hubbard squash Jellied banana salad Indian pudding • Tomato rice soup Browned hash - catsup Baby green limas Garden salad Cherry filled cookies	**5** Nectarines Hot or ready to eat cereal Poached egg Toast • Salmon with lemon Buttered potato balls Creamed peas Chinese cabbage - French dressing Fruit filled melon ring • Split pea soup Crabmeat, Mornay Stuffed baked potato Sliced tomato salad Daffodil cake	**6** Fruit nectar Hot or ready to eat cereal Scrambled eggs Toast • Chicken with dumplings Buttered noodles Diced carrots Pickled beet salad Royal Anne cherries • Creole soup Spiced tongue Corn fritters - syrup Fruited cheese ball salad Blackberry tart	**7** Sliced peaches Hot or reeady to eat cereal Baked Egg Biscuit - jam • Broiled ham slices Marshmallow sweet potatoes Frozen asparagus tips Pineapple cherry salad Vanilla ice cream • Rice soup Cheese, tomato rarebit on crackers Julienne potatoes Shredded lettuce Ice box pudding
11 Blended fruit juice Hot or ready to eat cereal Country sausage Toast • Swiss steak Oven browned potatoes Corn on the cob Grapefruit apple pinwheel salad Peanut brittle tapioca • Scotch broth Creamed chicken and ham on biscuits Franconia potatoes Grated vegetable salad Fresh peach short cake - whipped cream	**12** Grapefruit sections Hot or ready to eat cereal Scrambled eggs Toast • Baked halibut Au gratin potatoes Fresh spinach mound Carrot raisin salad Lemon snow - raspberry sauce • Cream of tomato soup Tuna noodle bake French style green beans Gingerale salad Sugar cookies	**13** Stewed apricots Hot or ready to eat cereal Shirred egg Cinnamon toast • Swedish meat balls mushroom sauce Paprika potatoes Buttered Zucchini Pepper slaw Boston cream pie • Alphabet soup Canadian bacon Stuffed baked potato Tomato escarole salad Lime sherbet	**14** Crushed pineapple and bananas Hot or ready to eat cereal Crisp bacon Blueberry muffins • Beef pot pie Steamed rice Buttered broccoli Molded vegetable salad Pistachio ice cream • Bouillon Bologna in rolls Macaroni au gratin Pickles - relishes Fruit compote
18 Tangerine nectar Hot or ready to eat cereal Scrambled eggs Toast • Creole pork chop Mashed potatoes Buttered wax beans Cinnamon apple ring salad Frosted doughnuts • Split pea soup Toasted cheese roll-ups French fried potatoes Asparagus cut up in milk Tossed garden salad Apricot tart	**19** Stewed prunes Hot or ready to eat cereal Poached egg Toast • Codfish cakes - tomato sauce Buttered crumb potatoes Frozen peas Cucumbers - sour cream dressing Spice cake • Vegetable beef soup Open faced sandwiches Escalloped corn Stuffed celery Fresh fruit cup	**20** Fresh grapes Hot or ready to eat cereal Buckwheat cakes Syrup • Roast short ribs of beef Creamed potatoes Broccoli Wilted lettuce Burnt almond charlotte • Tomato rice soup Liver pattie with bacon ring Potato puff Fresh fruit salad Gelatine cubes marshmallow sauce	**21** Kadota figs Hot or ready to eat cereal Canadian bacon Toast • Braised chicken Whipped potatoes Buttered Brussels sprouts Tomato petal salad Pepermint fudge ice creeam • Hot vegetable juice Roast beef sandwich Baked potato Cole slaw Fresh fruit Honey date bars
25 Grape juice Hot or ready to eat cereal Baked egg Pecan rolls • Beef ragout Buttered noodles Peas and carrot cubes Fresh fruit salad Ice cream sundae • Okra soup Escalloped potatoes and chipped beef Cole slaw Blueberry pinwheel-lemon sauce	**26** Orange tidibits Hot or ready to eat cereal Oven French toast Preserves • Panned trout - lemon Potatoes in jackets Julienne green beans and celery Lettuce - Chutney dressing Pineapple mint sherbet • Clam chowder Ham - asparagus roll Escalloped potatoes Molded beet salad Sponge cake	**27** Rhubarb sauce Hot or ready to eat cereal Poached egg on toast • Roast beef Browned potatoes Creole eggplant Frozen fruit salad Cake with fresh cherry sauce • Vegetable soup Sausage links Broiled tomato half Butterscotch biscuits Shredded lettuce salad Fresh applesauce	**28** Sliced oranges Hot or ready to eeat cereal Bacon curls Pecan coffee cake • Baked ham Oven browned potatoes Cauliflower with cheese sauce Chiffonade salad Ice cream sundae • Vegetable soup Chicken salad on toasted roll Potato flakes Carrot sticks Fresh pear Gingersnaps

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Roop

Continued from page 99

in surgical suites, primarily major and minor operating rooms, that the operating room team may vary from one to 20 persons. Are the proper authorities aware of this factor when considering design in this area? Are they cognizant of the fact that surgical procedures today run from 20 minutes to as much as 12 hours or longer? All parties on the planning team must become acquainted with the varying degrees of occupancy and problems related to hospital operation.

Patients today are requiring a range of space temperatures in their rooms from 70 to 84 degrees. Many systems are designed to give a maximum temperature of 76. Why must the owner face patient complaints *after* the installation of a system that does not meet the needs of our customers? These are only a few examples of many varying temperature requirements that will be found throughout the entire hospital plant.

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Costs today are most important and present a problem not only to the hospital that is initially concerned with the installation of an air conditioning system in a new or old building, but is also concerned with the operating and maintenance cost. Do not purchase an air conditioning system on first cost alone; consider that you, as a hospital administrator, will be faced with a continual high operating cost if proper design criteria and basic operational requirements of your system are not satisfied.

Cost determinations may start with proper filtering equipment on your air conditioning system. This filtering equipment should be purchased with the thought in mind (in addition to filtration efficiency) of continued maintenance costs, month after month, year after year. There have been great strides made in the field of air filtration within the past 24 months. Consider all of these that are available from (1) electric, (2) electronic, and (3) mechanical systems; together with a combination of the one, two, or three systems mentioned.

The cost to own and operate an

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*Thiamine	1.2 mg.	FAT	30 Gm.
*Riboflavin	2.0 mg.		
Pyridoxine	0.5 mg.		
Vitamin B_{12}	5.0 mcg.		
Pantothenic acid	3.0 mg.		
*Niacin	10.0 mg.		
Folic acid	0.05 mg.		
Choline	200 mg.		
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The unparalleled versatility and precision of this new table are an incomparable aid to the surgical team . . . as helpful to the patient as "a third hand for the surgeon."

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Changing Professional Liability Patterns

Civil Liability—Claims Based Upon Negligence and Damages

by Grace C. Barbee
Staff Attorney
California State Nurses' Association
San Francisco, California

Part II

Part I is on page 110 of the August issue.

What are some of the trends? Consider *Cooper v. National Motor Bearing Company, Inc.*[5]

A judgment of $15,000 was rendered against a nurse and her employer. The nurse treated an employee for 10 months before referring him to a physician for a facial injury; cancer and surgery resulted. The *negligence* was the: *"Inaction of the nurse in the presence of signals of danger which would have moved a reasonably intelligent"* nurse promptly to refer the employee to a competent physician.

The Court used interesting language, which I believe does not carry the significance that some claim for it, but there it is. You can decide for yourself.

In its instructions to the Jury, the trial Court said: *"The same degree of responsibility and the same duty of care is imposed upon a nurse in the making of a diagnosis as is imposed upon her in the prescribing and administering of treatment."* There was a judgment against the nurse, and the case was appealed.

The Appellate Court still used *"diagnose"* and *"treat"*, but indicated its limitations on the trial court's instruction when it said:

> *"A nurse in order to administer first aid properly and effectively must make a sufficient diagnosis to enable her to apply the appropriate remedy. Usually she receives some history of the accident or illness from the patient, inspects a wound, and bases her choice of treatment on the deductions thus made . . . . she should be able to diagnose . . . sufficiently to know whether it is a condition within her authority to treat as a first aid case or whether it bears danger signs that should warn her to send the patient to a physician."* The court felt it was not probable that the jury confused the standards of *"diagnosis"*. demanded from a nurse with those of a doctor.

There are those who see real significance in the court's use of the words "diagnose," and "treat." Time alone will tell.

Let us look at some other trends.

Who Is Liable?

Profit Hospital. The employed nurse, in addition to being personally liable in damages for injuries to a patient, may *also* make the employer liable. Generally, a private profit hospital, or a doctor, is liable for the negligence of the nurse employee.[6]

Non-Profit Hospital. If the employer is a non-profit hospital, it depends where you are as to what the law is. It is an area of confusion. The confusion led the Supreme Court of Arizona[7] to exclaim and quote Pascal: *"How ludicrous is reason, blown with a breath in every direction."*

All states hold the nurse liable for her own negligence. Some states, including Oregon[8] find the non-profit employer is not liable for the negligence of an employee. Still other states hold the employer liable if it was negligent in employing the nurses or, like the State of Washington,[9] the hospital is liable if the injured person was a *paying patient.* Still other states like Arizona and California hold that charitable institutions are liable for the negligence of an employee which causes injury to a third person, *"whether stranger or patient and whether the patient is a paying or non-paying patient."* The national trend is toward greater liability. California joined the absolute liability group in 1951 when the Supreme Court of California decided the case of Malloy v. Fong.[10]

From the point of view of the nurse this double liability of employee and employer must be considered from two angles. Where the hospital is also liable for the nurse's negligence, the negligent nurse is not only jeopardizing herself but also her employer. She does not lose her liability because her employer is also liable. But in states or situations where the non-profit hospital is not liable for the negligence of its employee the injured patient only can look to the nurse for damages.

Governmental Agencies Liability Trends. Employees of state or local Governmental agencies cannot "share" their liability. The "sovereign" employer is not liable for

[5]Cooper v. National Motor Bearing Company, Inc. 136 Cal. A 2d 229 (1955).

[6]Welsh v. Mercy Hosp. 65 Cal. App. 2d 473.

[7]Ray v. Tucson Medical Center, 72 Ariz. 22.

[8]Langraver v. Emanuel Lutheran Charity Board. 280 P 2d 301 (Oregon) 1955.

[9]Pierce v. Yakima Valley Memorial Hospital 260 P 2d 765 (1953).

[10]37 Cal. 2d 356.

Now everybody's talking...

about... *closer control of cross infection in every part of the hospital*

Wider recognition of the current problem of hospital-acquired infections is focusing new attention on ways and means of reducing this hazard to good patient care. Hospital and medical society meetings—and hospital, medical and surgical journals—are daily shedding new light on the varied aspects of the overall problem.

In many hospitals, a special "committee on cross infection" has been appointed to review practices and procedures. In others, each department head is studying closely his or her own methods of operation. Few hospitals exist which are not giving some special thought to this highly current problem.

Out of this critical evaluation has grown an awareness that environmental asepsis is a major weapon for cutting cross infection to a minimum. Application of continuous disinfection procedures from operating rooms through food service and laundry areas can be the means to changing the hospital's entire experience with hospital-acquired respiratory, intestinal, urinary or post-operative wound infections.

Take floors, for instance

Floors offer a great opportunity for furthering the spread of infection. Microorganisms settling to the floor are redispersed on dust particles or tracked through the hospital on shoes. Walls and ceilings as well can be reservoirs of potential infection. Lehn & Fink disinfectants not only kill all the most common pathogens on contact but are continuously active against new contaminants touching the disinfected surface for as long as a week later.

While the patient is there

Concurrent disinfection is practical whether or not the patient is "isolated." Wiping of furniture and fixtures and damp mopping of floor, with a disinfectant, stop air- and floor-borne microbes at the source.

In the operating room

Lehn & Fink disinfectants have many applications here. Among them: mopping floors; cleaning grills, ducts, and coils of air conditioners; as standard equipment on the scrub-up cart; as a germicidal dip to remove gross contamination from gloves before their removal; to gather instruments into enroute to sterilizer.

Other L & F disinfectant applications are many: for disinfection of instruments with lens systems, to wipe and store thermometers, to sanitize utensils, etc. In all instances, action is bactericidal, fungicidal and tuberculocidal.

Which L & F disinfectant?

Lysol®, O-syl® and Amphyl® do the same disinfecting job. Any one of them kills bacteria, fungi, and TB bacilli efficiently, but each has individual characteristics.

Lysol was far ahead of its time when introduced over sixty years ago. Recently the formula was improved; the odor was lightened and toxicity was reduced so that the "poison" label is no longer needed. Many hospitals prefer Lysol because of its long reputation for dependability. The characteristic odor is preferred by many for psychological reasons or as an indication that disinfection with Lysol has just been done.

O-syl is preferred by hospitals wanting all the germicidal efficiency of Lysol but without the odor. It is practically odorless when diluted for use. Like Lysol, O-syl is highly concentrated. Only a 1% solution of either (1 part to 100 of water) is needed for most applications.

Amphyl is also odorless when diluted for use. Convenience and low cost due to its high concentration often make Amphyl the disinfectant of choice. Amphyl is twice as powerful as Lysol or O-syl but does not cost twice as much. A ½% solution (1 part in 200 of water) is sufficient for general disinfection so that the cost per gallon of "use dilution" is less than with Lysol or O-syl. When expected contamination is great, as in TB or isolation wards, Amphyl is often preferred.

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the negligence of its employee. The injured patient again only can look to the nurse for damages.[11]

In California, governmental immunity continues to be recognized but judges are being critical.

One judge quoted the Harvard Law Review.[12] *"There is little reason to doubt that the genuine interest of the public would be well served by abrogation of the long-accepted immunity rule."* The judge held, however, that any change must be achieved by legislation and not by court decisions.

New York recently abandoned its time-honored concept and passed a law waiving sovereign immunity.

Where governmental immunity exists, and it exists in most areas, the immunity does *not* extend to physicians or nurses.

Employees of Governmental Agencies. California has held a nurse, employed by a county hospital, liable for injuries sustained as the result of want of attendance upon a patient while in a delirium. The hospital was not held liable for the employee's negligence.[13] Recognizing the vulnerability of governmental employees, California laws authorize a Governmental agency to buy liability insurance to protect its employees.[14] Under Section 2002.5 of the Government Code, if a state employee is sued for malpractice alleged to have arisen out of the performance of duties as a state employee, the employee can demand that the Attorney General defend the suit. The State is authorized to pay any settlement or judgment *"arising from acts of employees of the State in the performance of their duties on the grounds of state institutions or facilities or by reason of emergency aid given to inmates, state officials, employees, and to members of the public for accidents occurring on such grounds."*

Private Duty Nurses — Trends. A private duty nurse cannot *"share"* her liability, for the hospital is not her employer. She is an independent contractor and the injured patient can only look to the private duty nurse for damages.

However, where a private duty nurse requests necessary lunch relief from the hospital staff, interesting patterns may develop. In a recent case the attorney for the nurse, and the attorneys for the hospital arrived at a compromise judgment, each to pay a half of the settlement agreement. The private duty nurse had asked the head nurse on the floor for relief while she went to lunch. The head nurse said the patient would receive necessary care. On the next day the private duty nurse called the head nurse telling her she was going to lunch. The patient fell while the private duty nurse was at lunch. No general duty nurse was present at the time of the fall.

Proving a Nurse Was Negligent. Usually a person who sues for injuries claimed to have been caused by a person's negligence has the burden of proving beyond a reasonable doubt that someone was negligent.

The legal rule of *res ipsa loquitur* —the thing (the injury) speaks for itself—is an exception to the burden of proof rule.

The rule of *"res ipsa loquitur"* has been used in the *"missing sponge"* cases. Its use is spreading. This is exemplified by the California case of *Ybarra v. Spangaard*[15] where a patient filed a suit for damages against the hospital, several nurses and doctors in attendance upon him during an appendectomy. While unconscious, the patient suffered a traumatic injury to a nerve in his right shoulder, causing a paralysis of the right arm.

There was no testimony of any one person's negligence. The patient proved that he had no shoulder injury when he went into surgery. When he regained consciousness after surgery his injury existed. Each defendant doctor and nurse testified he saw nothing occur which could have produced the injury. *The Court held that where a patient receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries could be liable.*

Since the person suing did not have to probe the negligence of the nurse, in order to recover damages from her, the implication for nurses, as well as for hospitals and doctors, is important.

Other cases have involved the same principle of law.

In a recent case,[16] the Iowa Supreme Court considered the doctrine of *res ipsa loquitur*. The plaintiff had surgery on her back; she awoke from anesthesia with first, second and third degree burns on her abdomen. The Court held that: the doctrine of *res ipsa loquitur* is a simple understandable rule of circumstantial evidence.

> *"We think it is a just and logical conclusion that one who, while undergoing a surgical operation, sustains an unusual injury to a healthy part of his body not within the area of the operation, be not precluded from invoking the doctrine of res ipsa loquitur in an action against the doctors and nurses participating in the operation.*
>
> *"It was sufficient that plaintiff disclosed that the injury resulted from an external force applied while she lay unconscious in the hospital."*

Supervising Nurses

A supervising nurse permitted a patient, after surgery, to suffer symptoms of growing pathology for three days without medical care, despite reports to her by staff nurses. She failed to act because the patient's attending physician was not available. The court held the supervising nurse, alone, was liable.[17]

A nurse is, of course, liable for her own negligence; the employer can also be liable for the nurse's negligence. In general, a registered nurse is not liable for the negligence of other hospital employees. However, a registered nurse could be held liable for injury resulting from the negligence or incompetence of a student or assistant; (a) if the R.N. delegated duties to a student or other assistant, knowing that the assistant was incompetent to perform the delegated duty, perhaps because of insufficient basic instruction or demonstration; or (b) if the R.N. delegated duties which the assistant was competent to perform only with adequate supervision, and then failed to give the supervision.[18]

We have considered the experiences of some nurses who have faced malpractice claims. Their experiences are measures of the total problem. Their experiences should be a guide for, and not a deterrent to future growth.

Thoughtful professional performance, based upon sound preparation and full appreciation of legal responsibilities and protections, are nurses' safeguards as they practice.

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[11] The federal government has waived total immunity through the Federal Torts Claims Act.

[12] 54 H.L.R. 437.

[13] Griffin v. County of Colusa, et al, 44 Cal. App. 2d 915. See also: Madison v. City and Co. of S.F. 106 Cal. App. 2d 232.

[14] Section 1956, Government Code.

[15] 93 Cal. App. 2d 43.

[16] Frost v. Des Moines Still College of Osteopathy and Surgery, 79 N.W. 2d 306 (Iowa) 1/18/57.

[17] Valentin v. La Societe Francaise 76 Cal. A 2d.

[18] Piper v. Epstein 62 N.E. 2d 139.

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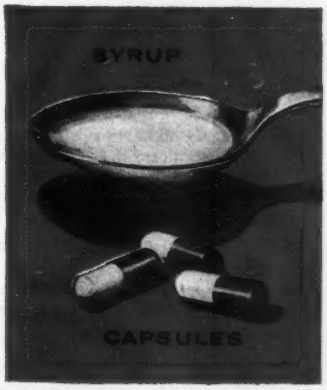

MSD MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa.

Continued from page 106

air conditioning plant today, including 20-year amortization and utilities only, will run from $1.16 per square foot of building area per year in a new building to a cost of $1.26 per square foot of building area per year. However, do not forget other operating costs such as supplies, equipment, and payrolls.

In considering operating expenses in our air conditioning plants, we must take into consideration such factors as water treatment, preventive maintenance, personnel, operating conditions, (such as weather conditions, study of seasonal loads, peak loads, and degree days) and the patient. A prime and basic consideration of good air conditioning design must consider the patient in direct relation to operating costs, and inconvenience of maintenance and services required to operate such a plant.

Keep all mechanical equipment out of the patient's room. It is costly to management for "call-back" service when it is impossible to maintain or enter a room for equipment maintenance. Central dietary service in today's hospitals has received wide acclaim and is readily accepted. Let us apply the same theories and ideas to the installation of mechanical equipment required for air conditioning systems. Centralize your system so that the patient will not be disturbed from maintenance and preventive maintenance routines.

In centralizing the mechanical equipment required to provide conditioned air, the type of refrigeration equipment to be purchased as well as the degree of central control for this equipment should be studied. The location of this equipment and the relationship to personnel required, utilities available, and ease of operation can influence the decisions required of owners, architects, and engineers. ■

Table 1. Comparison of Hospital Air Conditioning Systems

			Central Plant Systems (20 yr.) Chilled/Hot Water — Steam			
					High velocity	
	Window	Self-contained	Zone A.H.U.-low velocity	Individual fan coil units in room	Conduit-induction coil unit	Double duct
Life	P	F	E	F	E	E
Control	P	P	F-E*	P	E	E
Noise	F	F	E	F	E	F-E
Heating	P	P	F	F	E	E
Vent	F	F	E	E	F	E
Filter	P	P	E	P	P	E
Odors	P	P	E	P	F	E
Insulation	No	No-Direct				
		Yes Distribution	Yes	Yes	Yes	Yes
Cost per ton ($)	300+Htg.	750+Htg.	850+Htg.**	900	1,000	1,100
Maintenance	P	F	E	P	F	E
Floor space	E	F	F	E	E	E

P — Poor (5-7 years); F — Fair (7-10 years); E — Excellent; Htg — Heating
* "E" With zone and individual room control; **In southern climates separate heating may be omitted.

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Preventing Infection From Hospital Linens

by Leon T. Cooke

■ THE PROCESS of living and sustaining life becomes more complicated every day. There are new diseases and greater importance is given to the diseases that have affected us for years. New treatments for disease are being produced regularly and some of these treatments bring complications of their own.

The hospital laundry manager is an essential member of the hospital family. He is interested in any threat to the well-being of his community. As the need for hospital care increases his duties increase in proportion. He too must be prepared to process hospital linens in any emergency.

The manner in which his responsibility is carried out has a decided affect upon the health and welfare of the patients in the hospital which he serves.

Increased Laundry Responsibilities

A few years ago the laundry manager saw his job as simply to launder and return all the linen that was sent to his department in the least amount of time. He was not particularly worried about the health of the patients who were to use his processed linens. He thought that the patient was under good medical supervision and nursing care. Nothing could happen to the patient for which he might be responsible. In fact, he knew very little about the patients who used his laundered linens. He really had no way of knowing if anything went wrong.

Today the picture is different. The conscientious laundry manager knows that he plays an essential part in the over-all therapy of the patient. He is more than ever conscious of the careful and hygienic manner in which his laundered linens are processed. Because he does not have the time nor the equipment he must rely upon the valuable assistance of the laboratories and research departments of the laundry and allied trades industry. They do their best to keep him abreast of all the latest developments in the field of laundry science.

Almost every serious problem which the hospital laundry manager had a few years ago has been overcome with some new product, process, or equipment. Those problems which have not been solved satisfactorily are being studied. Millions of dollars have been spent by the laundry allied trades industries to make the hospital laundry manager a person of knowledge and a valuable asset to the institution he serves. Service is just as important to the laundry manager as is the procuring of supplies. The allied tradesman is anxious to supply that needed requirement. Machinery and products are being developed and are in use today. They provide the maximum opportunity to produce clean and sterile hospital linens.

The processing of hospital linens is a science in itself. Much thought is being given to improving service and to removing contamination that might be traced to the laundered hospital linens. It is a matter of concern that an otherwise healthy patient can contract an infection while in a hospital bed under perfect nursing care. The need for a study of the hospital laundry manager's responsibility is in order.

Rules For Clean Linen

Some of our hospital laundries have very few rules for handling clean linens so as to prevent contamination before the processed linens reach the patients in the hospital beds. After the linen is washed with the proper washing supplies and passed through the ironing machine, presses, and driers it is free of germ life.

But the moment it is taken from the machines and placed upon the folding table, handled by unsterile hands, placed upon a dusty shelf, exposed to germ-laden air, placed in unclean trucks and passed through the processes of handling and re-handling until it reaches the hospital bed, it loses its sterility.

Contamination can hardly be avoided under the best of existing conditions. The physical condition of the employees handling the clean linens contributes to the spread of disease. The equipment used in transportation of clean linen also contributes substantially to contamination.

If we could imagine a laundry with adequate ventilation and laundry employees wearing masks and clean white gloves, ultraviolet-ray lamps distributed throughout the clean linen area to destroy germ-life in the air, and other such preventive precautions, we could still expect some microbes to be conveyed on the clean linens to the hospital beds.

Most hospital laundry managers are conscious of these facts and conditions. They are doing everything in their power to prevent con-

Mr. Cooke is with the Calgon Company, Pittsburgh, Pennsylvania.

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tamination. They try to keep their equipment and working areas clean. They insist that their employees be clean and neat. Some even provide their employees with clean garments to wear while handling hospital linens. Some managers provide freshly laundred liners for laundry baskets and trucks that deliver clean linens to the hospital. They cover the linens with clean covers to protect them during transportation.

Some hospitals still transport soiled linens in the same baskets that are used to transport clean linen. A load of soiled and infected linen is brought to the laundry from the hospital operating room, kitchen, or nurses' home and placed in the washing machines. The basket that conveyed the soiled linen to the laundry is then placed near the flatwork ironer and then filled with clean linen to be returned to the hospital. No preparations made to protect the clean linen from the contaminated basket. Sometimes the tissues and refuse in the bottom of the baskets are not even cleaned out.

Separate Trucks

Most hospital laundries have separate trucks for the transportation of the soiled linen and the clean linen. Some hospital laundries have separated rooms for the handling of soiled linens and clean linens. But some of our hospital laundries handle the soiled linen and the clean linen in the same room and sometimes in the same small working area. Some of these rooms are in a basement with no sunlight and very poor ventilation. It would be remarkable indeed if the clean linens were not thoroughly contaminated before they left the hospital laundry.

This situation is a source of deep concern to all hospitals. Every avenue of disease prevention is being explored and the laundry department must come in for its share of examination. Germs and microparasites are quite capable of living outside of the human body, in the environment of air, water, and other materials intimately associated with human life.

Disease prevention is an important part of the laundry manager's problem as the linens that he processes in his laundry can very easily contribute to the spread of infectious disease. It should be of sufficient importance to hospital management to make a survey of processed linens so as to educate laundry employees in the sanitary handling of the hospital linens.

The spread of disease germs is an expected and accepted fact. We do not, however, want it to be expected that clean linens, travelling from a hospital laundry should be a conveyor of disease germs. By careful and intelligent supervision, by proper physical conditions and by the use of clean and sanitary equipment, the incidence of spread of disease can be greatly reduced and possibly entirely eliminated.

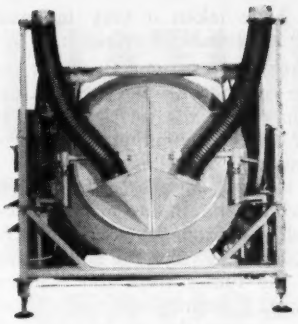
Though we can hardly expect, under present conditions, to deliver absolutely sterile linens to the bedside we can strive to deliver it as clean and as sterile as possible. Certain companies are exploring the possibility of producing a residual germicidal product which, when used in the washing process, will render the linens germ-free from one laundering to another even while the linen is in use on the bed.

Infectious Lint

A study made at a Boston hospital revealed that minute particles of lint distributed through the air from the bed linen of a patient suffering from a contagious disease can be carried to infect another patient in another part of the hospital. By means of cultures hung in various parts of the hospital rooms and corridors it has been established that the lint, shaken from the linen on a contaminated bed, was carried through the air, out of the door of the hospital room and into the corridor and thence into the other rooms in the hospital. A single minute piece of lint from a contaminated bed sheet can support enough germ-life to infect an otherwise healthy patient down the corridor from the patient's room where the contamination occurred.

We know that we inhale disease germs with almost every breath we take. But in most instances our bodies are in the proper condition to resist infection from disease germs so taken into our systems.

The problem of airborne infection has become so important that drastic steps are being taken to overcome it. There are products now in use that either prevent the linting of bed linens or reduce it to a minimum. This, in itself, is a very important development and is quite desirable. By using a product in addition to this which will render the bed linens germ-free we



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will have taken a very important step in disease prevention.

Though these new products may be in common use very soon it does not preclude the necessity of sanitary and hygienic methods of processing and handling the linens in the hospital laundry. The laundry in which the linens are processed should be properly ventilated. The dust and lint from the soiled linens and the fumes from the machines washing contaminated linens should not permeate the air in which the clean linens are handled or stored. The clean linens should be handled by clean hands, protected from contaminating dust and dirt, and placed in carefully protected sanitary conveyances. They should be placed on sanitary shelves in the linen closets in the hospital and there protected from contamination. They should not be stored in closets with unclean or used blankets or bedpans. They should not be stored in a closet where employees hang their coats and other clothing while on duty.

Many hospitals are making up separate *"packs"* containing a prearranged amount of linen which is carefully wrapped and delivered to the hospital room or ward. If these are prepared, delivered, and stored under rigidly sanitary conditions they can contribute greatly to the elimination of the spread of cross infection.

When we patronize a nice restaurant we like to imagine the clean, sparkling, sanitary kitchen in which the food is prepared. Some of us have visited and admired such immaculate kitchens. We were impressed with the cleanliness and with the clean white uniforms and caps that the kitchen employees wore. We gathered the impression that every effort had been made to give us the cleanest and the best of food. The management had every reason to be proud of its kitchen and of its employees. They most certainly gained the confidence of their patrons.

Some of our hospitals perhaps could have every reason to be proud of their hospital laundry. If it were practical, they could invite their patients to view and admire the department in which their linens were processed. The nurses should be proud of the appearance of the uniforms processed in the laundry and every department that uses the services of the laundry should be pleased with the service that the laundry renders.

Recommendations

Much can be done to prevent the spread of disease germs in the processing and handling of hospital linens. We offer the following suggestions.

1. Separate and distinctly marked conveyances should be used to transport soiled linen to the laundry.

2. The area in which soiled linen is stored, shaken out and separated should be well ventilated, and separated in some manner from the area where clean linens are handled and processed.

Lint and dust from soiled linen should not be permitted to settle in the clean linen area. Employees who handle soiled linens should not immediately handle clean linens without precautions being taken to prevent contamination.

3. A special washing formula with special washing supplies and an ample supply of hot water should be provided to remove and destroy contamination from the linens.

4. Sanitary washing equipment, extractors, and washroom trucks must be provided.

5. The area where clean linen is processed should be well ventilated. It has been said that the laundry manufactures lint. It floats through the air and it settles over everything. Every effort should be made to remove lint from the air by proper ventilation. Many laundries have a ventilating hood over the ironing machine which catches both steam and lint from the machine. Additional efforts should be made to draw the lint from the area surrounding the flatwork ironer where most of the lint is produced. In addition to a health hazard the lint is also a very great fire hazard.

6. Sanitary baskets and trucks, with freshly laundered liners should be provided for the transportation of the processed linen to the hospital services. The clean linen should be carefully protected from dust and lint during the transportation. These trucks and baskets should never be used to bring soiled linen to the laundry on the return trip.

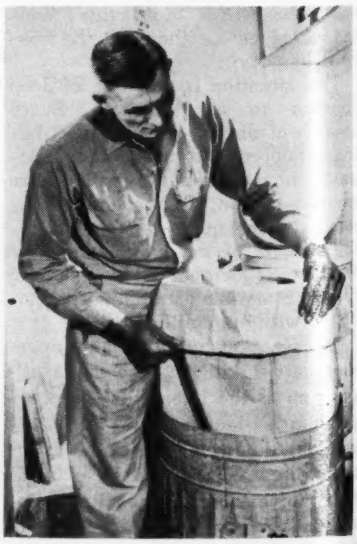
7. The laundry personnel who handle clean linens, should be in good health and should observe the common precepts of personal hygiene. A laundry employee suffering from a contagious illness, such as a common cold, should not handle clean linens. Laundry workers should be dressed cleanly and keep their hands clean. A hospital should, from time to time, give the laundry employees a careful medical examination to prevent a diseased person from handling clean hospital linens.

8. If the linens are stored in a linen room before delivery to the hospital bed this room should be sanitary and well ventilated. Linens that are not distributed immediately should be covered and protected from dust and contamination. Used blankets and soiled clothing should never be placed in the linen closet. It should not be used for a utility room.

Many more suggestions could be made. Each situation must of necessity require its own rules and regulations. Almost every hospital laundry is different in physical characteristics. But it is possible, even in the most discouraging situations, to exert a maximum effort towards clean, sanitary handling of processed linens. A hospital laundry manager, with the proper encouragement, can do much in proving the old adage concerning *"an ounce of prevention"* and if the administration will give him the support that he needs, he can prove that old adage over and over again. ■

Heavy Duty Can Liner Available

■ AVAILABLE NOW is a large, heavy duty paper can liner for disposing of hospital and surgical wastes. These wet strength liners are manufactured to fit standard 30-gallon cans. Tops of bags can be twisted for "ears" so that there is no actual handling of waste by your janitors. Push trucks will hold 20 to 30 of these bags. ■



NEW Ideal COMBINATION

. . eliminates loose ends in CENTRAL FOOD SERVICE

IDEAL Mealmobile, Model 9020-BCT with built-in beverage dispenser and mechanical refrigeration.

The new IDEAL Mealmobile with mechanical refrigeration and built-in beverage dispenser, together with the new Idealmobile, Model FS-100, hot food assembly unit, now make it possible for you to have a complete food service system that is thorough, fast and efficient.

The Mealmobile with its mechanical refrigeration, can now be used as a cold food storage unit. This permits the loading of salads and other cold items well in advance of food serving time and eliminates peaks and valleys in the work load in the kitchen. The new IDEAL Mealmobile in combination with the new Idealmobile hot food assembly unit, enables you to move foods directly from the hot food preparation area to the most convenient assembly area — thus speeding up food service.

The complete IDEAL centralized food service system introduces a cyclical operation in the movement of food from kitchen to patient . . . done the same way every time. And efficiency increases each time!

This IDEAL combination offers efficient centralized food service for all hospitals—regardless of size. Additional units may be added to meet your needs —present and future.

Idealmobile Model FS-100 hot food assembly unit

Write for assistance in your kitchen planning

Ideal® HOSPITAL EQUIPMENT
Found in Foremost Hospitals

Made only by the
SWARTZBAUGH MANUFACTURING COMPANY
MURFREESBORO, TENN.

For more information, use postcard on page 143

Management Aids

927 — Color Chart

■ A FREE CHART showing 36 colors of a new multi-purpose maintenance and product paint for metal, wood and masonry is offered by Carter Paint Company. The new coating is designed for heavy-duty interior and exterior use on such surfaces as buildings, machinery, floors, walls and other like items.

928 — Gas Sterilization

■ A LINE of completely automatic, low temperature gas sterilizers is described in Wilmot Castle Company's catalog. The sterilizers described are available as self-contained units or the control system may be adapted to existing bulk installations for use with gas alone or with steam and gas alternately.

929 — Deep Frying Pointers

■ A GUIDE to best methods for producing pleasing fried foods is available from Procter and Gamble. The purpose of this booklet is to outline and explain the best frying methods.

930 — Mock Up Plan For Vending Installations

■ VENDING MACHINE equipped automatic feeding and refreshment stations can be planned in miniature with the Vendo Company's 34-piece planning aid. The kit contains all the materials required to lay out several types of vending machine installations including a full-line automatic cafeteria setup that offers employees everything from soup to nuts.

931 — Shallow Luminaires

■ PITTSBURGH REFLECTOR COMPANY'S new line of extremely shallow surface mounted luminaries, less than 3 inches deep, is featured in an eight-page two color bulletin. Two types are described, the Cleveland which comes in the 16 inch width, and in lengths of 4 feet and 8 feet; and the Shallowline which are square and rectangular shaped modular units in keeping with present architectural trends in lighting design.

932 — Planning Catalog

■ A 24-PAGE FOOD and drink equipment planning catalog offered by the Chicago Hardware Foundry Company, to architects, designers and owners, shows the latest in stool and table design, color selection and installation ideas. The products highlighted in the catalog illustrate forward steps in beauty and utility for institution interiors.

933 — Fats and Oils in the Diet

■ AN eight-page booklet, "Facts and Theories About Fats and Oils in the Diet" has been prepared by the Wesson Oil People for distribution to professional personnel in the medical and nutritional fields. The booklet answers the many patients' questions prompted by the recent publicity concerning diet and the heart. It draws no conclusions concerning fats, rather it reports in simple, lay terminology the known facts and assumptions about fat and its place in the diet.

934 — Ice Flaking Machine

■ Low cost and high efficiency in the production of a high-grade crushed ice for use in food and drink service, is emphasized in a new brochure describing Scotsman ice flaking machine. The brochure shows two basic types of ice flakers; eight individual models are described in this pamphlet. ■

Continued from page 94

training program set forth in the syllabus on "Central Sterile Supply Administration" is excellent, and would give fine preparation to the student pharmacist for administrative supervision. Indeed such a comprehensive program of training could make a CS supervisor out of a good upstanding dust mop. Here again, with your opportunity to be heard and read through the medium of a leading hospital periodical you have failed to defend the nurse who pioneered the growth and development of this field *without* the benefit of such an organized training program.

"This article points out that 'one or two registered nurses would be needed to carry out the less important functions of the Central Service department.' The inference is that the professional nurse is a necessary part of this vital operation, but that she should be subordinate to the pharmacist, who is going to receive the prestige, and certainly the paycheck commensurate with the title of Administrative Supervisor of Central Service.

"We fully realize that this article may be only a report on what is going on in the field, but we also strongly feel that if an RN editor did not have the privilege to speak in behalf of the nurse as the Central Service supervisor, successful without the arm of the pharmacist on which to lean, it would be better that this RN editor would not have her name on the publication, with the inferred endorsement.

Very truly yours,

THE INTERSTATE CENTRAL SERVICE ASSOCIATION

The reply:

"First of all, please let me say that I cannot tell you how much I appreciated your frank and complete expression of opinion concerning the December article in HOSPITAL MANAGEMENT. I am very sure that your group is well aware that there are a number of Central Supply (not primarily Central *Service*) departments that are being supervised by pharmacists. Some leaders in hospital administration feel that if the Central Supply, or Central Sterile Supply Service, is in the department of hospital administration,

Central Service Idea of the Month

■ A "GADGET" which seems to work (although it sounds as if it wouldn't) is employed in the Central Service Department at Victory Memorial Hospital, Waukegan, Illinois. An eight-inch length of large size rubber tubing, 5/16 inch lumen and 3/16 inch wall, is closed at one end by use of a shut-off clamp. Beginning near the closed end of the tube, soiled needles are inserted into the tubing just far enough for the entire point to be inside. By use of a bulb syringe, detergent solution is forced into the open end of the tubing and thus through the needles. Rinsing is accomplished the same way. A plugged needle is instantly detected, and may be removed for further processing. Mrs. Maynard, C.S. supervisor, reports very few "rejects" with this method, and scarcely any damaged points. This might well be employed in a hospital with a small enough number of needles to consider mechanical cleaners too expensive, yet where disposable needles are not yet available. ■

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"AerVoid" The Best Known Name in Portable Food Service Equipment — Is Proud To Introduce Its Newest And Most Needed Development.

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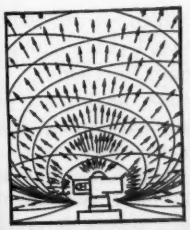
• IT PRE-HEATS

All done easily and simply by foot pedals - And with mechanical precision.

"Its Pedal Operation" is as simple as stepping on the gas pedal of your car

It's a "MUST" wherever Refuse Cans—Mixing Kettles—Stock Pots —Milk Cans—Large Kitchen Utensils and Insulated Containers need cleaning and sterilizing or pre-heating—Saves time and labor costs—Does a better and more sanitary job—FASTER!

Its "Revolutionary" Cyclonic Whirling Spray Nozzle (Ball-Bearing) propels a powerful 3 directional Jet Spray which sanitizes every minute crevice with a Scouring Action — It operates with Low or High boiler pressures.



Cyclonic Scouring Action

"IN COMPLIANCE"
With Sanitary Construction Requirements (Items 10 and 12 — Ordinance and Code Regulating Eating and Drinking Establishments) of the UNITED STATES PUBLIC HEALTH SERVICE.

Write To Dept. HM-19 For FREE Literature

AERVOID — SINCE 1913 —

Vacuum Can Co.
19 S. HOYNE AVE. • CHICAGO 12, ILL

For more information, use postcard on page 143

Note imbedded Nylon plug locks screw automatically
SEXAUER
EASY-TITE
Note Fiberglas backing — resists closing squeeze

NEW WAY TO

Prevent Faucet Leaks!

★ **9 out of 10 washers are fastened with screws that are TOO LONG or SHORT. The screws quickly loosen; the loosened washers are destroyed thru grind and squeeze of opening and closing faucets.**

34 years of research uncovers new solution

★ **Now, NEW (Patented) 'Sexauer' SELF-LOCK Monel screws, with an imbedded expanding NYLON PLUG, lock at the required depth AUTOMATICALLY, hold washers FIRMLY! Made of rustproof, non-corroding Monel, heads don't twist off, screw slots don't distort. They are easily removed when necessary, can be re-used repeatedly.**

★ **Used with NEW 'Sexauer' EASY-TITE faucet washers, they make a combination that outlasts past faucet repairs "6-to-1"! EASY-TITES are made of super-tough, pliable du Pont compound (neither rubber nor fibre) and reinforced, like a tire, with a vulcanized layer of Fiberglas. They resist distortion and splitting from shut-off grind and squeeze.**

Hidden costs of faucet leaks!

Faucet leaks are costly! As authenticated by Hackensack, N. J. Water Co. and American Gas Association, stopping just ONE PIN-HOLE SIZE (1/32") LEAK can reduce water waste 8,000 gal. quarterly. If a HOT WATER FAUCET LEAK, water and fuel savings JUMP to over $7.58 QUARTERLY—plus additional savings on MATERIALS, LABOR and costly FIXTURE REPLACEMENTS!

NEW SELF-LOCK screws and EASY-TITE faucet washers are just TWO of the "SEXAUER" line of over 3000 TRIPLE-WEAR plumbing repair parts and Pat'd. precision tools.

A "SEXAUER" Technician in your vicinity will make our NEW 126 page Catalog "H" available. He will gladly consult with you regarding a SURVEY of your plumbing fixtures to determine correct repair parts required and establish reasonable stock levels that avoid both overstocking and shortages—thus providing for efficient stock arrangement and control—all without obligation. WRITE TODAY!

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WORLD'S LEADING SPECIALISTS IN PLUMBING AND HEATING REPAIR PARTS

it could well be placed under the supervision of the pharmacist. Naturally, if it is in the department of nursing, it is logical to expect that a nurse should be in charge.

"Because we have readers of both schools of thought, and in order to present as many viewpoints as possible, I included the position of the American Society of Hospital Pharmacists. I am sure that you noticed that I was careful to say, 'The *pharmacists* have been saying that this (supervision of C. S.) is a natural function of a hospital pharmacist.' And again, 'whether or not this is the ideal arrangement is not a question that can be decided here.' Then, if you look closely, you will see that everything from the beginning of the third paragraph on page 76 to the very end of the article is enclosed in quotation marks.

Actually, I could not be more in agreement with you than I am. *Of course* I think this department belongs to a nurse — whether or not it is actually a part of the department of nursing. You see, merely presenting the claims of the opposition does not necessarily indicate agreement on the part of an editor."

In his study of 110 hospitals, of which 35 were governmental and 75 nonprofit, with a range of 29 to over 500 beds, Frank O. Salt of the University of Virginia Hospital, Charlottesville, Virginia, found that all but one hospital had a female registered nurse as supervisor of the original C. S. department. Fourteen (12.7 percent) have changed to a different type of supervisor. These now include five L.P.N.'s, two G.N.'s, one aide, five lay persons and one hospital corpsman. This subject is attracting attention of students in Hospital and Nursing Administration. Miss Naomi B. Jones of the University of Washington, Seattle, has chosen this matter as a graduate project. She, along with others, finds a real draught of materials for reference.

The Central Service editor of HM is eager to compile information with regard to the trends of C. S. supervision. A souvenir copy of "Resolutions for a Central Service Supervisor" will be sent to those who fill in the questionnaire below and mail it to

Central Service Editor
Hospital Management
105 W. Adams Street
Chicago 3, Illinois

Central Service Supervision Study

1. Name of hospital _____
2. Address of hospital _____
3. Government____ Not-profit____ Proprietary____ No. Beds____
4. C. S. supervisor is Nurse____ L.P.N.____ Pharmacist____
   Other (please specify) _____
5. How long has present type of supervision been in effect? _____
6. If changed from R.N. to other type, why? _____
7. Number of employees in C. S. _____
8. Name of C. S. Supervisor _____

"The Delicate Art of being a Heart . . ."

There is a fine art
In being a
Heart—
A fact which we all well know;
But it takes lots of digging
To interpret the rigging
And restore its "status quo."
With its tachycardia, bradycardia,
sinus arrhythmia too,
More T voltage, less T voltage,
slightly more prominent Q;
Negative T waves, large QS waves,
auricular fibrillation—
Upright T's, extrasystoles,
left axis deviation.
This delicate organ
Has its own
Jargon—
A tangle of turn-about phrases;
But its job as a pump
Keeps it right on the "jump"
And worthy of myriad praises.

With its damaged left ventricle,
ischaemic right ventricle,
digitalis effect,
Insignificant changes, myocardial
changes, auricular flutters unchecked—
Sagging ST's, arterial disease, right
axis deviation:
Diphasic T's, bigeminis——small
wonder it cries for vacation!!

JOAN WRIGHT

—*From Canada M.A.J.*

The Search for Value

by Robert E. Shillady
President
National Association of Purchasing Agents
General Purchasing Agent
New England Electric System Companies
Boston, Mass.

This is the second part of a three-part article. The first part appeared in August.

Check Performance

However, there is a potential danger that the purchasing agent may become complacent and satisfied with following the easiest path, which generally is the preservation of the "status quo." He may fail to constantly check the performance of his suppliers until he suddenly is awakened by finding that his plant is being hampered in production by recurring shortages of some necessary material or by lack of uniform proper quality and working characteristics of the material. On investigation then, he may find that there has been a change in management of the formerly good supplier and that his emphasis now is on expanding volume and obtaining new customers, even though this may be resulting in a change for the worse in the product which he is selling or poorer service to his old customers. Now and then you find a sales manager who is so obsessed with the idea of expanding his business by obtaining new customers that he forgets or takes for granted his old customers and in this way leaves the door ajar for new and previously untried suppliers to walk in to the purchasing agent and persuade him to give them a trial. And such a new supplier may perform a very useful service, even though he may at first seem to be a "pest," if his sales representatives are intelligent and show a spirit of progressive co-operation coupled with reasonable pressure which keeps the purchasing agent alert and regularly checking to see that his company is getting the value for which it is paying. At the present time in my own company I am quite concerned about a change in the performance of a supplier who is very large and generally outstanding in his industry. We have done a large volume of business with him over a good many years and still think he should be a fine source of supply. But some months ago we were interested in a new type of application of his product. We arranged for his sales representative to talk with our engineers and suggested that he bring in proper engineering talent. He did this and we presented to them the problem that we desired to solve, suggested what appeared to us a feasible, and efficient means of accomplishing this and asked them, as experts in the line, to examine and test our method or offer something better. They seemed somewhat indifferent, and although their local sales organization tried to prod them into giving us an answer we wasted several months without getting either a reply that our suggestion was impractical or the presentation of some other method or substitute.

After the loss of this time and effort on our part, we talked along the same lines to another manufacturing organization that was a comparative newcomer in the business. Their men showed keen interest in our problem and our tentative solution and set up to manufacture on a test basis some of the type of material which we suggested as well as a couple of other types on which there was some information in the industry. All of these were carefully tested as to results and thoroughly examined as to manufacturing methods and costs. We finally decided on one type (it happened to be a slight modification of our original suggestion) and placed a substantial order at a price much lower than we could obtain for any previously existing alternatives and also with lower installation costs for ourselves. This experience impressed us with the alertness and forward-looking engineering and manufacturing of the newer organization and has resulted in their obtaining a substantial volume of our business on other standard products—with the larger and long established company which had once been our prime supplier being relegated to a secondary position. I am concerned about this because we have had many years of pleasant relationship and good service from the first company and I am sorry to see it getting fat and lazy and indifferent because of size, and trying to live on past good reputation. I would like to have two or more suppliers in this line who are progressive and alert and are continuously trying to give us the best possible values.

I think a sound decision requires that the purchasing agent analyze the performance and capabilities of his present sources of supply to determine whether their manufacturing and research organizations are alert and aggressive and have kept abreast of progress in new methods, and whether there is a strong desire to continue to earn business by giving maximum values. If the answers to these questions are favorable, then it is probable that the untried potential supplier would have little to offer to the purchaser who has taken pains in the developing and checking of his existing sources of supply. But if the answers are not fully satisfactory, it will be necessary for the purchasing agent to get very busy and develop new and better sources.

But we should also keep in mind that if the purchaser expects and

demands loyalty from his suppliers, he should also extend loyalty to them and not drop them just because someone else comes along with a plausible story—this, of course, on the basis of the purchaser being critically satisfied that he is obtaining the best possible value on a continuing basis.

Thus far, in our search for value in the purchasing of materials, equipment and services, we have considered the elements of suitability, the ability to obtain them in the quantity and at the time desired, the dependability of and service given by the manufacturer or vendor, and the desirability of fostering and stimulating sound and legitmate competition and developing more than one dependable source of supply. Last, but by no means least, we should fit the element of price into the whole picture.

Fundamentally, prices are determined by the interplay of the forces of supply and demand. Even in cases where there have been governmental regulations which interfered with free markets and attempted to fix prices, we have seen "black markets" and exorbitant prices developed in commodities where the immediate demand was greater than the supply; and we have also seen other articles which were in good supply selling at prices lower than those which were allowed and originally thought to be fair. The efficient purchasing agent will keep closely in touch with the basic conditions affecting supply of the principal commodities which he buys and will endeavor to make his purchases or commitments when the supply-demand situation is favorable. ■

Morale, What Is It?

by R. G. Schreiber

■ IT IS certainly something I would not begin to define. Call morale what you will your organization either has it or is just going through the motions.

It is not necessary to look around for morale for the evidence will come without looking for it. Maybe one of your department heads was picked up by the speed analyzer for hurtling through your town at 35 m.p.h. in a 25 m.p.h. zone and has to plunk down $12.50 for the fine. Someone in your organization gets a large paper bag, collects a total of 98 pennies and presents it to the department head. That is morale in my book.

Is there a rivalry among various department heads as to how additional savings can be made in their departments? In your meetings is there a spontaneous response by the department head or a dead silence?

A while back a visitor with a young child sat in our lobby nervously awaiting a bus to take them home. An employee noticed how nervous the lady seemed to be and inquired if he could help. She stated she was awaiting the bus which was due in a few minutes. The employee went just that extra little bit further and asked her how far she would have to walk after she got off the bus. When the employee learned that it was a half mile, he drove them home across town through the snow.

It is a good feeling too, to find that your department head has already taken care of an item which you had intended to call to his attention.

Are your department heads on their toes and ready to change a

Please turn to page 136

NATIONAL ASSOCIATION OF HOSPITAL PURCHASING AGENTS

Applying Engineering Principles in the Procurement Department

by Fred Knight

I have been reading some case histories regarding the struggles of small institutions in financing of expansion and replacements. The struggles of small institutions to raise funds to provide capital additions serve to emphasize further the importance of dollar conservation. Many who spend public funds are apt to think in terms of the job and the problem first and then the cost. This, however, is not a sound approach. Nevertheless, it is never prudent to be penny wise and pound foolish. However, there are few people today who spend funds of others who are *not* cost conscious. Perusal of the financial dailies, attendance at meetings of the purchasing agents association, and daily contact with your own controller will take care of that in most instances. Inflation factors now on the European and Asiatic horizon certainly underline the problem of inflation and probably underline it in red ink in many cases!

Hospitals today are big business; they rank fifth in the nation.

In planning purchasing work, it is largely a matter of tailoring the available cloth to the particular job or institution. Words are cheap—advice free and often of little value. Hence, this is only offered by way of constructive suggestion and will need to be applied like peanut butter—sparingly.

Consider several elements:

A. What are the duties of the purchasing agent? Are they defined as to scope, responsibility and authority? Are they in writing? Have they been given publicity to the organization? If not, they should be. The use of the manual or procedure guide will be of material assistance in any organization large or small.

B. How much time is dedicated to the function of purchasing? If it is not a full-time job, a definite schedule ought to be worked out to permit the proper time to be allocated without infringement by other responsibilities.

C. How much purchasing is actually done?
   1. Dollar wise?
   2. By number of orders?

   The number of confirming orders placed by others is a routine clerical operation and should require little time on the part of purchasing.

D. What policy is followed in regard to interviews and conferences with staff and supervisory personnel?
   1. Sales representatives
   2. Administrative personnel
   3. Departmental heads and staff
   4. Subordinate employees

After some breakdown of the above has been indicated and other important considerations reviewed, it would certainly seem desirable to develop an organizational plan or chart establishing, first of all, the chain of command and second, fixing the duties and responsibilities of each individual. Such a plan, of course, will be quite simple in a small organization or office family. However, the importance of being double barrelled is not something to sniff or dream about.

Illnesses, vacations, death, disaster and promotion are contingencies that overtake even hospitals.

Perhaps it would not be out of line to observe that budget consideration will fix the number of salaries and the number of people in any administrative office. This of course will be true in purchasing. Administrative directives should establish the scope and limit of duties and responsibilities mentioned above. The organization chart will actually outline and layout the chain of command.

This speech was given by Fred Knight, director of purchases, University of Illinois, Chicago Division, Chicago, Illinois at the Tri-State Assembly to the Chicago Area National Association of Hospital Purchasing Agents.

The above may be somewhat dogmatic and perhaps represents over simplification of the problem in many organizations.

Now, I would like to make some suggestions that may have merit.

1. Make a time schedule or time plan. It will not always work but it will help with the budgeting of time which is one thing none of us seem to get enough of.
2. Try to make rounds. Visit the store room, receiving dock, critical areas as early in the day as possible. This will encourage punctuality in your associates and subordinates and will frequently provide information that can be processed the same day that it is received. This will permit the clearing of transactions with sales personnel and the answering of phone inquiries promptly. It will alleviate grief and grievances and reduce friction with staff due to the fact that the problem has at least been reviewed and answered promptly, whether or not the solution is completely effective. This will stimulate the impression that the purchasing department is efficient and, in turn, will give the purchasing agent a good name.
3. Salesmen are often thought to be "time killers". However, they are valuable source of information and are necessary for many reasons. If the purchasing agent does not follow the golden rule in dealing with them, he need not expect much in the way of emergency service on rush orders, price consessions, expediting, and so forth. And when the chips are down, it is frequently found that the salesman is the best friend you have. No salesman need be allowed to waste the time of the buyer or his own—20 to 30 minutes will suffice for most interviews. A good buyer should be able to weed out the men from the boys, the salesman from the peddler. Two to three minutes is enough for the peddler.
4. Plan your day so that you can handle correspondence, requisitions and sign orders at a regular time. This allows time for preparation of correspondence, typing of orders, and will encourage efficiency on the part of those who do the typing, handle the letters, vouchers, and do the filing.
5. Daily work. The matter of handling mail and phone calls is a simple matter. However, we are of the opinion that these rate a high priority. The impression that others on your own staff and vendor representatives have of you may be governed by the way you deal with them. Prompt reply to letters and phone calls will lead to a good impression.
6. A well-prepared, authentic and specific purchase order with good specifications, complete delivery instructions, and all essential information also leave a favorable impression on the part of those handling the order.
7. Be prompt in payment of invoices. Good vendor relations and minimum amount of dealing with credit men and cash discounts claimed are the reward for this.

In the handling of complaints and claims for damage, perhaps a good word to use might be "snappy". If these transactions are handled with dispatch, the results will be more satisfactory than otherwise. Emergency orders and emergency requirements must, of course, take precedence over all other transactions.

Provide parking facilities for your salesmen. This is one of the irritations of being located in the metropolitan area and can be alleviated by providing a few stalls for the men who answer your phone calls and wait upon you in the reception room. An item that should not be overlooked is the provision for a satisfactory receiving dock and unloading facilities. Friction with truck drivers and teaming contractors is an old story.

Here I might stress the importance of adequate follow-up of orders and correspondence. There is nothing more embarrassing to the purchasing agent than to find that he has not answered a letter or has not followed up an order with the result that the department is irritated and the vendor nonchalant about the whole thing.

A good set of simple, understandable office forms will do a great deal to stimulate efficiency and conserve time in purchasing.

All of these items contribute to the good will that can be generated. Some of these factors will actually save money for your hospital.

In an effort to streamline the work in purchasing, I would like to pose for you several small questions:

How much of the purchasing work can be done effectively —

A. By contract—for a definite dollar quantity or contract for a period of time.
B. By blanket or standing orders.
C. By petty cash purchase made by authorized personnel in amounts not to exceed $5 to $10.
D. By routine orders—standard items and sources using standard sources where the prices can be checked from a catalog price sheet or other information.
E. By competitive bidding.

First of all, does the volume of orders justify the number of people in the office and the procedures that have been established to handle this work?

Second, does the dollar volume and the potential savings possible warrant the expenditure of time and energy. Each person, each procedure, each form, each step should be tested. A simple test is to ask the question, what useful purpose does it serve? If the answer is unsatisfactory, vague, or dubious, further analysis and check seems indicated.

We are believers in frequent reports to management in some systematic way. These will point up the activity or efficiency or lack thereof in the department and will give the entire office a personal evaluation of itself. The frequency and formality of these reports will of course be dictated by the type of organization and the people who will read them.

In conclusion, the willingness of the purchasing agent or the buyer to attack a hard job with energy. Intelligence, and efficiency will certainly give added stature to purchasing. Sometimes it is necessary to burn a little midnight oil on some of problems. However, checking with some of your friends and associates in other hospitals, calling in a friendly salesman, looking at the solution of other people, will help with these. The personal satisfaction for such a job well done is adequate reward. However, it is notable that management often recognizes and takes account of these things. When new programs are started, purchasing is more likely to be called in at the planning stage if they have volunteered and shown an energy in handling some of the hard problems.

Time spent attending your association meetings can and should be very fruitful. You learn much from sharing with your professional associates. ■

The "Sixty-Four Dollar Question" Column

Permission to reprint this Column each month for the National Association of Hospital Purchasing Agents was granted by Mr. Frank M. Rhatigan, secretary of the American Surgical Trade Association.

QUESTION: ***Advise source of supply for Ikle epidural syringe used in anesthesia.***
ANSWER: Fa Ulrich, St. Gallen, Switzerland.

QUESTION: ***Advise name of manufacturer of plastic micro slide box to hold 100 three inch by one inch slides.***
ANSWER: Glasco Products Co., 111 N. Canal St., Chicago, Ill.

QUESTION: ***Advise address of Sano-Fresh, Inc., which makes deodorizers. Reported to be in Chicago but we cannot locate them there.***
ANSWER: Suttle Equipment Co., 135 S. LaSalle St., Chicago 3, Ill., manufactures the Sano-Fresh Deodorizer.

QUESTION: ***Where can we obtain a soft plastic Airway such as formerly made by Zoller Chemical Co., which is now out of business?***
ANSWER: Available from Schuco International London Ltd., 22-25 Bartholomew Square, Old Street, London, E.C. 1, England, which is an affiliate of Schueler & Co., 75 Cliff St., New York, N.Y.

QUESTION: ***Do you have information as to where we can obtain equipment for administering ionized air negative used in the treatment of burns?***
ANSWER: Wesix Electric Heater Co., 390 First St., San Francisco 5, Calif.; also Katadyn-Filter S.A., Wallisellen, Zurich, Switzerland.

QUESTION: ***Who makes a digital phephysmograph (plethysmograph) which is used to measure blood volume going through toes and fingers?***
ANSWER: One developed by Dr. Travis Winsor of Los Angeles is being manufactured and sold by Electro-Medical Engineering Co., 2317-A West Olive Ave., Burbank, Calif.

QUESTION: ***Looking for a plastic airway used in mouth-to-mouth resuscitation. One end fits into patient's mouth and the administrator blows into the other end to start patient's breathing.***
ANSWER: The Foregger Co., Inc., 55 W. 42nd St., New York 35, N.Y. makes one of rubber, designed by Dr. Peter Safar of Baltimore, Md.

QUESTION: ***Can you advise address of Ellfield Laboratory? Believe it is a veterinary supply company.***
ANSWER: 6400 Rhode Island Ave., Hyattsville, Md.

QUESTION: ***Who makes a cast remover known as Kast-Off?***
ANSWER: "Kast-Off", Mr. Winfield S. Hoover, P. O. Box 8782, Dallas 16, Texas and also available from Chas. E. Dove, Jr., 2715 Merle Hay, Des Moines 10, Ia.

QUESTION: ***Who makes a plastic Goniometer such as described in Special Volume 166 No. 7 of the A.M.A. Journal issued on Feb. 18, 1958?***
ANSWER: Rehabilitation Products Division of American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill. and available from them and V. Mueller & Co., 320 S. Honore St., Chicago 12, Ill.

QUESTION: ***From whom are lithium oxalate pills for 5cc blood available?***
ANSWER: Cambridge Chemical Co., 5850 Chase Rd., Dearborn, Mich.

QUESTION: ***Who makes "Diamond Edge" scissors with copper or brass plated ring handles?***
ANSWER: Snowden-Pencer Corp., P. O. Box 186, Los Gatos, Calif., V. Mueller & Co., 320 S. Honore St., Chicago 12, Ill.; and Codman & Shurtleff, Inc., 104 Brookline Ave., Boston, Mass. makes these with goldplated ring handles.

QUESTION: ***Who manufacturers the Inject-Tainer, which hold 36 needles up to 1½ inches? Requires no forceps to apply to syringe?***
ANSWER: Made by Will-Pen Co., P. O. Box 1036, Decatur, Ga., in two types, "A" for autoclaving and "B" for boiling. Distributed by Donald W. Edwards Co., Inc., 1947 Broadway, New York 23, N.Y.

QUESTION: ***Advise source of supply on plastic disposable or semi-disposable surgeons gloves, two-finger and five-finger.***
ANSWER: A. S. Aloe Co., 1831 Olive St. St. Louis 3, Mo. and Plasticsmith, Inc., P. O. Box 415, Concord, Calif. We understand Aloe is selling their disposable glove to surgical supply dealers at an attractive discount and suggest that you get in touch with them if interested.

QUESTION: ***We are interested in a stainless steel teapot made by Gesler Mfg. Co. Advise address of company.***
ANSWER: Gessler Corp., 1 Joralemon St., Brooklyn 1, N.Y.

QUESTION: ***Advise source of supply of long asbestos gauntlet for removing items from autoclave.***
ANSWER: Minor Rubber Co., 49 Ackerman St., Bloomfield, N.J.; Dunn Products, 1222 W. Madison St. Chicago 7, Ill.; Wheeler Protective Ap-

parel, Inc., 230 W. Huron St., Chicago 10, Ill.; Kaul Glove & Mfg. Co., 1435 Brooklyn Ave., Detroit 26, Mich.; and Safety Products Division, American Optical Co., Southbridge, Mass.

QUESTION: ***Where may we obtain new molded plastic stethoscope tubes?***
ANSWER: Becton, Dickinson and Co., Rutherford, N.J. make plastic stethoscope tubing but it is extruded, not molded.

QUESTION: ***Advise name of mfg. of Everseal Anti-Static M I E face mask.***
ANSWER: Available from Edwards Surgical Suplies, Ltd., 289 City Rd., London, E.C. 1, England.

QUESTION: ***Need information about needles with polyethylene tubing attached.***
ANSWER: Randall Faichney Corp., 299 Marginal St., Boston 28, Mass. Understood to be the only manufacturer of the original Gardner-Murphy scalp-infusion unit made up with polyethylene tubing.

QUESTION: ***Advise name of manufacturer of the Schonnander gas analyzer.***
ANSWER: N. V. Helofrint, P. O. Box 5142, Amsterdam, Holland exports this apparatus, known as the Micro Scholander Gas Analyzer, to all parts of the world.

QUESTION: ***Advise source on plastic or polyethylene microscope slide mailers.***
ANSWER: Bie & Bernsten, 35 Pilestraede, Copenhagen K, Denmark.

Attitude Makes the Difference

■ THE PANTRY MAID who picks up the patient's tray can approach the patient sympathetically and politely, taking care to inquire if the patient has finished, taking care to move across the room quietly, not to jar the bed or to intrude when privacy is indicated. On the other hand this dietary employee can think only of the stack of dishes that await her in the kitchen and the quicker she gets the trays picked up, the quicker she will get the dishes done and be ready to go home. The patient can appreciate the difference in the approach. What creates this difference? Attitude is the difference. ■

—Miss Margaret N. Hinkle, dietitian, Columbus Receiving Hospital, Columbus, Ohio.

New Service To Recover Silver From X-Ray Film Offered By Precious Metal Refiner

■ HOSPITALS AND CLINICS can now convert their old x-ray files into a worthwhile source of revenue. They can obtain this income by utilizing a new nation-wide service for salvaging the silver from used or outdated x-ray film, recently inaugurated by Handy and Harman, refiners and processors of silver, gold and other precious metals and alloys.

The refining service will enable radiology departments to reduce the bulk of used film files, free urgently needed storage space and, at the same time, dispose of the unwanted film at a profit. The quantity of film that can accumulate in the course of a few years is suggested by the company's surveys showing that the average 150-bed hospital uses about one tone of x-ray film yearly.

Handy and Harman's plan offers a choice of two options for handling the film. The company either will process it as a refining lot, or purchase the film outright on a per-pound basis, depending on the hospital's preference and the quantity accumulated. For shipments exceeding 2,000 pounds, the "refining lot" basis may be preferred for maximum dollar return to the hospital. On a refining lot basis, the hospital receives the full assay content value of recovered silver less a specified refining service charge. The recovered silver is paid for at the prevailing published market price of silver, now about 90 cents per troy ounce. For smaller accumulations, the outright-sale basis yields the best return.

The company has installed special facilities for processing scrap film. The often confidential and restricted nature of such film is protected by immediate and complete destruction as the first step in the salvage procedure.

The service is available on a nation-wide basis, and central receiving points have been set up to handle film quickly and conveniently from any locality. Full details of the silver-recovery plan are available on request from *Handy and Harman, 82 Fulton St., New York 38, N.Y.* ■

Editor's note: There probably are other such companies of which we have not heard, so check your own localities.

Fellow Thinker

Appreciation

Sweet is the music of words of appreciation.

All of us like approval of what we do.

It encourages us to do more and better.

Good deeds and good work are the seeds of progress.

We cannot progress without them.

He who cannot express appreciation for good work of others retards his own progress.

Appreciation is a powerful stimulant to do good work and enhances the power of the giver.

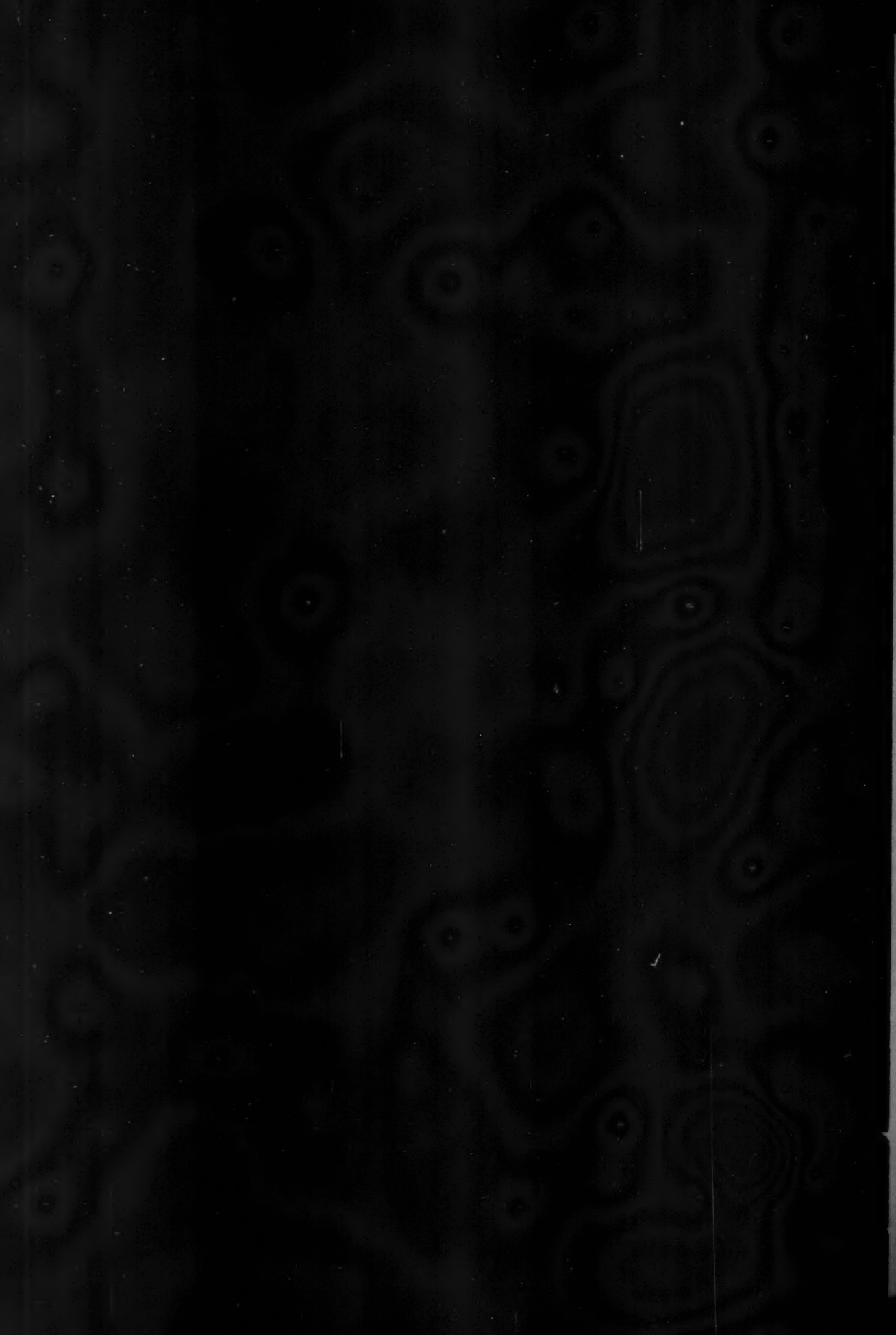
The best in a man comes out when his efforts are appreciated.

Appreciation adds strength and courage to defy all obstacles.

Appreciation serves humanity, when it encourages man to do his best.

John Glossinger

Reprinted from "The A.S.T.A. Journal."



Make It Money, Please!

by William A. Kozma

▪ How OFTEN have you answered your phone and found someone on the other end offering you an unwanted gift of a 10-inch-screen television set that doesn't work or some equally worthless item? It is difficult to turn it down, but after you read this you may want to develop a tactful way to say "no" lest you find yourself in the same predicament as our imaginary hospital administrator who tells this story.

"It all started a few years ago in a very simple way. We had to furnish some rooms in the quarters for male employes and I dropped a few hints around town that we could use some bedroom furniture. Of course, I was looking for fairly new stuff. I had no idea of becoming a dealer in used furniture.

"At first there was an occasional phone call offering a bookcase, a lamp, night table, an overstuffed chair (without the stuffing), a table with one leg missing, and a variety of broken chairs. Everybody entered into the spirit of the project, joyful to find a place to unload their garages, attics and cellars.

"Word of my need spread like wild fire and, as it spread, the need began to include anything and everything. I think the people in town tried to outdo each other in the amount of worn out junk that could be disposed of at the hospital. We received a variety of old ice boxes, crystal sets, batteries, kerosene lamps, commodes, and two grandfather clocks.

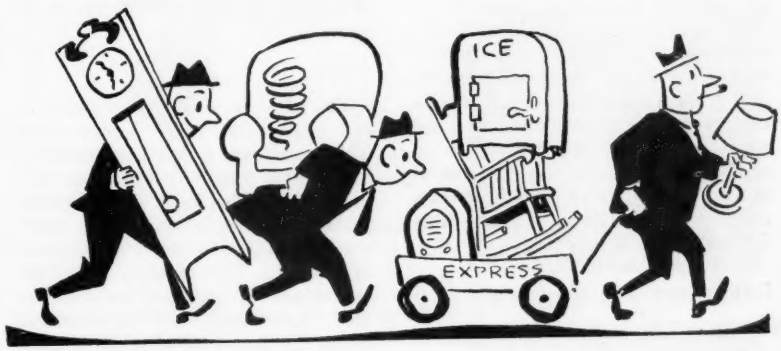
"Then we graduated from furniture as the word spread further. A local scientist sent in the equipment he used to produce a Frankenstein monster, two slightly used robots, and some assorted stuffed bats and black cats. Before the town's oldest mansion was ripped down, I had everything inside including the cobwebs.

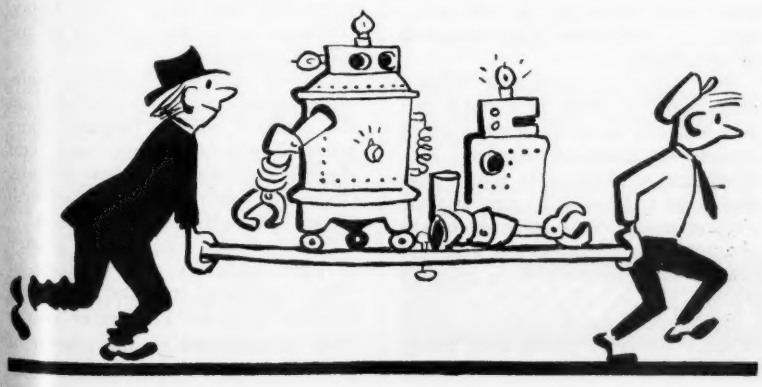
"It got to be quite embarassing as the Board of Directors began questioning how this got started. Several times I was awakened at night by some donor—who suddenly remembered a set of false teeth he had left in some piece delivered during the day.

"Perhaps the idea should have occurred to me sooner, but the hospital grounds looked like a hurricane had deposited the wreckage of six states before the thought struck; if it was so easy to get things out of the community, I'll just drop a hint around to make it money, please! If only half the response occurs, the hospital would be without a deficit for years.

"Lo and behold — it seemed no one in town had any old broken down money to give away. Word again quickly spread that I was out for money for the hospital. Pretty soon people began referring to me as an ungrateful cur. After all they had given to the hospital, I had the audacity to ask for money.

"It wasn't long before I was looking for another job, and believe me in the years since then I have made no reference to any needs save one — make it money, please!"





Mr. Kozma is administrator, Long Beach Memorial Hospital, Long Beach, New York.

Shopping Around

with Orpha Mohr

The Story of Institutional China

■ ANCIENT MAN molded clay into various shapes, and in firing them evolved the art of pottery. His progress in manufacturing methods and art is evidenced in the various pieces of ceramics that archaeologists have found in the ruins of ancient civilizations. Clays from diverse geographical locations produce different characteristics when fired, and wares from various parts of the world are distinguished by definite indicia of quality.

Today, ceramics is as much science as are the arts, and laboratory control has made it possible for present day potters to duplicate any clay formulas, and surpass in quality any chinaware of past periods. Of the three types of pottery made today for tableware, only one, chinaware, is acceptable for institutional use.

Earthenware

The body is quite porous. Most of this type of tableware breaks easily. It is opaque and has a dull, dead sound when tapped with a pencil. Much of the foreign ware imported into our country is of the earthenware type.

Semi-Vitreous ware

This ware is fired at a higher temperature than earthenware thus creating a harder body. This firing reduces the porosity (ability to absorb moisture) in the finished ware to about eight percent. It has a smoother texture than earthenware, an absence of a clear ringing sound when struck with a pencil and no translucency. In some cases this product is used by institutions since its cost is somewhat lower than vitrified ware. However, its ability to resist chipping and cracking is quite poor due to the fact that its lower firing temperature does not fuse the entire body of the ware and weak spots are inherent in its manufacture.

China

The clay is vitrified by firing to an extremely high temperature. This produces a hard, nonabsorbent body which keeps out dirt, grease, and bacteria. This nonabsorbent feature of chinaware holds even should the piece be chipped or cracked. This is then the product which is accepted as standard for most users of institutional china. Its cost may be slightly higher than the other types but it is more than offset by its ability to stand up under the usage demands of institutions.

True china is translucent. Hold a china plate in front of a light, and you will see your hand silhouetted against the back of the dish. Another test of china is to tap it with the finger. China will give a clear ringing sound. This is an exclusive characteristic of fine china, and will always distinguish it from cheaper wares.

Because of these qualities, china is more costly to produce. In firing, each dish must rest in a specially prepared holder, and allowance must be made for shrinkage under intense heat.

Clay for chinaware is very carefully refined. It is mixed with flint and feldspar in water, and the whole mixture worked into a thin paste called "slip". Further manipulating and aging brings the "slip" to a plastic, workable condition ready for shaping.

Throwing. A potter's wheel, revolving horizontally, is the basis of most shaping operations. In the past this shaping was done entirely by human hands as the ball of clay revolved with the wheel. Today, the forming principle remains the same. However the potter's wheel is a plaster of paris mold, modeling the face of the plate, while a steel tool, known as a profile, is held so as to shape the back as the clay revolves.

For other pieces of china, skilled hands still press the clay into the molds, work the shaping tools and trim and finish the ware. Eighty percent of the work in a modern pottery is hand work. China, today, continues to be the product of the skilled craftsman.

Casting. Shapes of certain elaborate pieces cannot be produced on the potter's wheel. Teapots, some sugar bowls, creamers, and odd shaped chinaware require casting. Only the more simple uniform pieces can be made on the wheel.

China casting requires a plaster of paris mold. A thin mixture of "slip" is poured into the mold and allowed to stand. The water in the "slip" is absorbed by the plaster of paris, leaving the clay on the inside

Material prepared in collaboration with John Hyer of Hinrichs & Co.

walls of the mold. When the clay has reached a proper thickness, the excess "slip" is poured out and the cast allowed to dry. The plaster mold is removed, the piece trimmed, smoothed and dried. It is then ready for firing.

Firing. The great heat used in the firing of china requires many precautions. Each piece must be handled individually. It is separated from other ware by nonfusing clay, then packed in saggers (special, protective, heat-resisting containers) and placed in the kiln where a very high temperature is maintained for many hours.

Warping and unusual shrinkage are likely to occur in the intense heat of the kiln, for the firing is at a temperature just below the softening or melting point of the clay.

Glazing. Glaze is the glossy surface of china. It is similar to glass in composition. In its unfired state it has the appearance and consistency of milk. By a process of dipping the glaze is applied, allowed to dry and then the ware is fired in a second kiln called the "glost" kiln, at a temperature slightly lower than that of the first firing. Formulas and conditions have been so perfected that the glaze of most china is immune to crazing, and silver will not scratch it.

Decorations on chinaware are applied in a variety of ways, then fired to fuse into the surface of the ware. Depending upon whether the design is put on before the glaze or after, it becomes known as underglaze decoration or overglaze decoration.

There are several kinds of decoration — decalcomania, copperplate printing, lining by hand, gold etching and shadowtone. To explain these in detail would require many pages; however, a short description will be helpful to you.

Decalcomania. Decalcomania is the transfer of a lithographed design in colors from a specially prepared paper to the chinaware. This decalcomania transfer makes possible exact reproduction of fine, intricate design. After the transfer is dried, it is fused on the ware by firing in another kiln at proper temperatures.

Printing. Printing is a process of design transfer which calls for the engraving of a copper plate. Color and design are transferred to paper from lines cut in a copper plate, and then in turn re-transferred to the ware. It usually is applied under

Please turn to page 136

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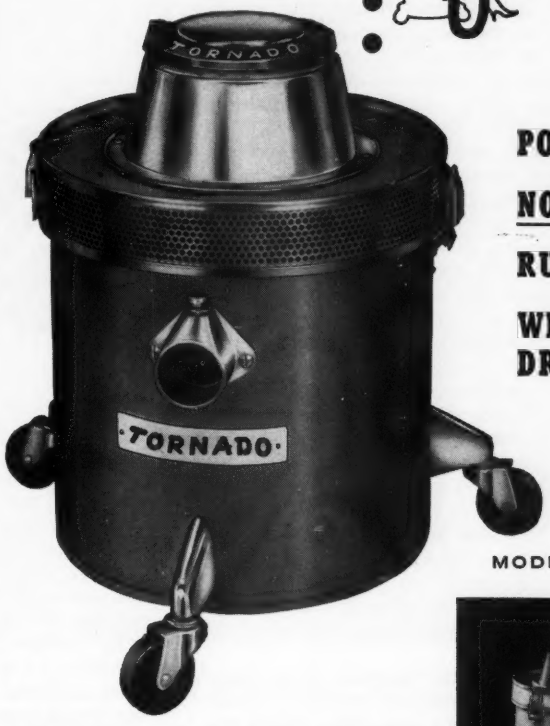

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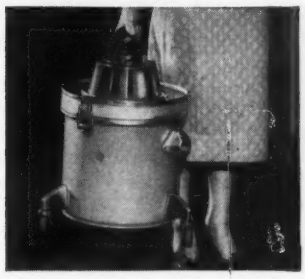

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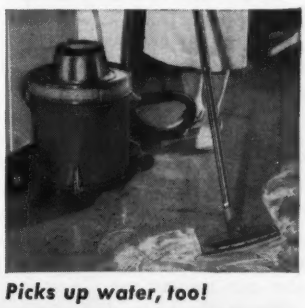

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For more information, use postcard on page 143

An Operating Microscope

by Herb Michelson

■ A NEW MEDICAL INSTRUMENT housed in Akron General Hospital has given increased hope to the hard of hearing in that Ohio city.

This instrument—an operating microscope—is owned by an Akron ear specialist but is housed and maintained in Akron General, one of the city's four hospitals. The administration permits the surgeon to keep the microscope in one of its operating rooms. The doctor works with the scope in the hospital's operating room, so it's only natural it be kept there. Should the doctor wish to move the scope to another hospital, General's officials wouldn't be moved to objection. The relationship is that casual.

Basically, this operating microscope is used in certain types of deafness cases. However, its use is not limited to the ear field. Gynecologists also may employ it for detecting cancer.

The scope actually is an instrument on wheels. This portability and mobility are among its key advantages. However, the prime factor behind the usefulness of the scope is the power of vision it gives the surgeon.

A head microscope previously used in some types of ear surgery provides double magnification. But the new microscope on wheels offers magnification of 40. Sighting through it, every blood vessel looks like the Red Sea. This tremendous magnification power provides, as the Akron surgeon says, "a much better chance of operating success because you can see much more."

Although the scope is new to Akron and an unknown instrument in many American hospitals, it is about ten years old and was developed by the Zeiss Optical Company of Germany.

The operation in which it's most commonly used is titled "stapes mobilization." Surgery must be delicately plodding.

The ear's three bones are the smallest in the body (you can see the need for surgical delicacy). These bones (in the middle ear) are commonly called the "hammer, anvil and stirrup" because these bones look like these names (this nonpedantic definitiveness is enjoyable).

The three bones are connected and work like levers. They transmit sound from the ear drum to the inner ear.

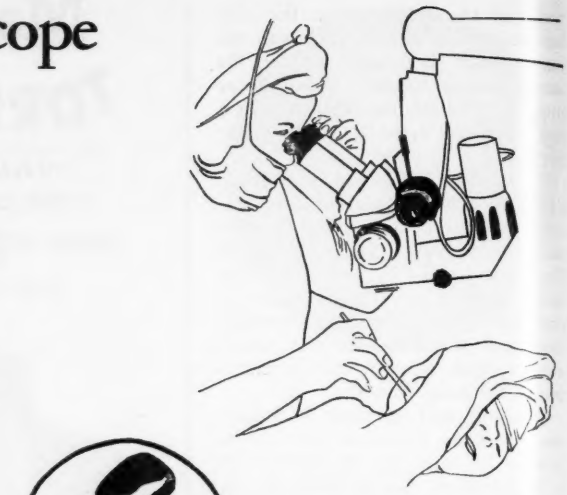
In the case of a 21-year-old woman, the stirrup bone in her right ear was frozen. It wasn't sending total sound to the inner ear. The surgeon's job was to unfreeze this bone and start the lever moving again. This is a "stapes mobilization" job.

This type of operation was abandoned at the turn of the century because of too much danger from infection. However, by 1950 antibiotics had licked this infection barrier, and the operation had its renaissance.

The young woman was given local anesthesia around the ear. An important point in determining the success of this operation is keeping the patient conscious so she can inform you how well she's hearing.

Naturally, an audiologist was at hand to record any improvement in the patient's hearing. But his story comes later.

The surgeon began his task using the aforementioned double-magnification eye loop microscope. A separate head light worn with this scope made him resemble a combination coal miner-Martian. He wore this apparatus for 45 minutes. During the opening stages of surgery, he made the incision, cut through the outer ear and then pushed aside the ear drum.



The doctor gets ← a good look

Now it was time to put the new microscope into action. Making the switch from the old eye loop scope to the mobile viewer had an air of drama to it—perhaps like the cavalry riding out of Cheyenne to aid ambushed settlers. (The analogy may be facetious, but perhaps you get the idea.)

The mobile mechanism was wheeled alongside the operating table. Its long arm (extending from a center post) extended about eight inches above the patient's ear, which was the only exposed part of her body.

The doctor removed his head scope and lamp, focused the new scope through the ⅜-inch ear opening. This scope provides its own light—in three colors. This is another advantage (the self-contained light, not the technicolor) of the new scope.

With the mobile viewer in use, the surgeon had only to glance through the double eyepieces to view his job. He didn't have to look directly at the ear.

When the stirrup was unfrozen, hearing tests began. A hearing device, placed in a sterilized sock, was positioned next to the ear while an audiometer recorded the hearing ability of the patient.

Being conscious, she was able to press a button indicating her hearing ability. These hearing tests were given at various stages of surgery, with the surgeon and audiologist huddling after each.

The hospital's management shows great interest in the ability of the scope. Will they buy one? One official of Akron General told me: "There are many instruments we'd like to purchase. Of course, there's always our budget to consider. We get a great deal of literature about new equipment and try to evaluate it from this point of view: what do we really need and what will be given the greatest use?"

Brochures always paint a prettier picture than budgets. ■

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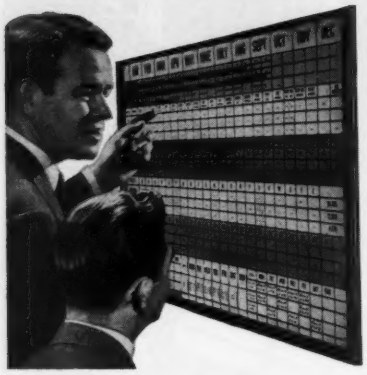

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Continued from page 26

organisms which then become pathogenic.

Recognize the Human Factor

Any machine or equipment is only as good as the individual using it. All the rules, regulations and controls mean nothing if hospital personnel do not constantly check themselves for human errors. Continuing education and eternal vigilance in the cause, effect, and elimination of infections, in addition to instituting proper control methods, are important.

The recognition and elimination of infections in patients and personnel are thought by many to be the most important single facet in the control of infections. No hospital employee with a carbuncle, boil, acne, paronychia, fungus infection, upper respiratory infection, diarrhea, common cold, or in fact any infection, should be allowed in contact with patients. The reverse is true of infected patients. They must be isolated. One of the commonest avenues overlooked is by the physician not notifying the admitting office of the presence of infection already in the patient, or the admitting office or floor nurse not recognizing its very obvious presence on admittance.

There is no single factor responsible for so-called hospital infections. There are many factors and causes and each should be investigated. The Joint Commission cannot supply and does not have literature on special techniques and treatments. For specific articles refer to medical and hospital library indices on the subject. ■

Hospital Pharmacy Advances

■ AS MEDICINE HAS progressed, so has pharmacy. By tradition, the responsibility of compounding medicine rests with the pharmacist, and to carry out his (or her) responsibility, the pharmacist must have skill, accuracy, and scientific knowledge of the composition, the properties, and uses of the drugs prescribed by the physician. Today, most of the drugs come from the large laboratories of manufacturing pharmacists but the very fact that compounds are not actually mixed in the pharmacy has increased rather than lessened the necessity of a high degree of skill and tremendous scientific knowledge by the pharmacist. Because most of the newer drugs are more potent as well as more effective than those used in the past, their use requires closer consultation and cooperation between the physician and the pharmacist and even greater care in dispensing drugs than in the past.

Within the past 20 years alone, the emphasis on the actual treatment of the patient rests more and more with the hospital pharmacy. Researchers are almost daily turning out new preparations or modifications of previously known drugs which are effective, but often costly, so that the patient's pharmacy bill may be higher than in the past, but only because there is more to be had from the pharmacist. His overall bill is actually less than in previous years because the modern drugs reduce the hospital stay, decrease mortality, and frequently render unnecessary many painful and expensive procedures common only a decade or so ago. ■

Are We As Bad As Eustace???

"No, sir," said Eustace Coleridge, "it's all wrong. What with the latest medical discoveries and the newest inventions, *a man dies just through carelessness.* I'm going to watch my step and live forever. SO . . .

He brushed his teeth daily with the right kind of toothpaste.

He had a complete physical examination every three months.

He always stayed inside when it rained.

He slept with his windows open.

He stuck to his diet, with plenty of fresh fruit and vegetables.

He had his tonsils removed and traded in several worn-down glands.

He played golf, but never more than 18 holes at a time.

He took trips, but only when the weather was good.

He never smoked—drank—or lost his temper.

He never worked under strain or drove himself.

He never worried.

FUNERAL NOTICE—The funeral of the late Eustace Coleridge will be held next Monday afternoon. He is survived by 18 specialists, 4 health institutes, 6 gymnasiums, and numerous manufacturers of antiseptic appliances and sanitary foods.

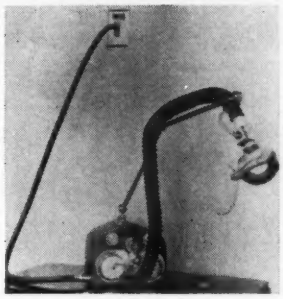
(*He had forgotten about driving too fast!*)

—*From Talelites.*

Product News and Literature

901 — **Breathing Unit**

■ A RESPIRATORY AID for victims of severe respiratory-pulmonary ailments. Delivers oxygen or a pre-set mixture of oxygen and air to a predetermined pressure whenever the patient takes a breath. Also for the administration of nebulized medications; or converted instantly into a manually controlled resuscitator which is operated by the rhythmic cycling of an emergency button on the instrument's control panel.



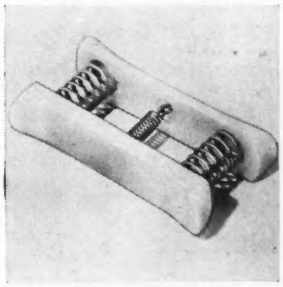
901

902 — **Adjustable Wood Shelving**

■ SHELVING is designed for heavy storage. Load capacity per shelf is guaranteed, by the manufacturers, at a minimum of 500 pounds. Shelves are adjustable every two inches and may be tilted forward for use as desk areas.

903 — **Big-Grip Exerciser**

■ BUILDS STRENGTH and coordination in hand, wrist and forearm. Contour shaped, durable polystyrene handles for easy and comfortable grip. Life-time springs calibrated in pounds of pressure carry torsional load from natural twist of hand when compressing.



903

904 — **Disinfectant-Detergent**

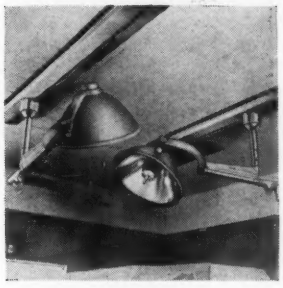
■ A ONE-STEP disinfectant-detergent for hospitals, which cuts labor costs on floor cleaning by the mop and pail method and by the machine scrubbing method.

905 — **Thermokup**

■ AN INEXPENSIVE, all-plastic cup; insulated; imparts no taste; transmits no heat and has no odor.

906 — **Twin Track Surgical Light**

■ FEATURED is the asepsis advantage, the long semi-enclosed tracks mounted on the ceiling outside of the immediate sterile area, the single arm reflector support which totally encloses all wiring and remote control elements, the dual heat control glass mounted within the 25 inch elliptical reflectors.



906

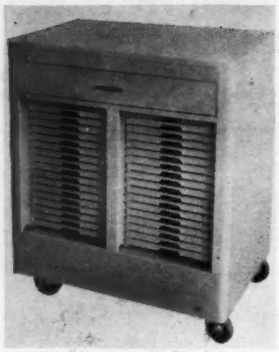
907 — **Shredding Machine**

■ DESIGNED expressly for office use, destroys confidential papers and old records, quickly and quietly. The machine is the size of a standard typewriter, it is electrical and needs no special installation.

908 — **Pneumatic Dispenser**

■ THE DISPENSER operates pneumatically at a press of its rubber foot-pump. Each pumping stroke delivers a measured amount of soap through the unit's stainless steel spout. The polyethylene container, which screws to the head and bracket, may be removed and refilled.

908



909

909 — Mobile File Cabinet

■ THIS UNIT makes possible the filing and storing of small records, such as graphs, charts and like items. Easily moved by one man, the cabinet offers a quick and economical way of maintaining daily graphs and refiling in the specified place.

910 — Oxygen Unit

■ THE UNIT uses thumb-size metal cartridges of oxygen discharged as needed, into an accordion-pleated breather bag of tough but elastic silicon-vinyl. The bag is attached to a mask assembly which contains a chemical filter that traps carbon dioxide during the re-breathing process. Operation is simple and safe according to the manufacturer. The unit can be used wherever oxygen therapy is indicated.

911

911 — Dispenser

■ SIMPLE snap-in dispenser features easy loading and dispensing. Saw-tooth edge provides easy cut-off. A wide range of standard nomenclatures are available for the pressure sensitive tape. Custom imprinted labels are also available to be used for identification.

912 — Soniscope

■ THE SONISCOPE will pick up sounds from the sound source with which it is in contact, and will reject any external sounds, and by correct use of the controls provided on the instrument, will enable the operator to attenuate any particular frequency not required, because "the instrument is provided with a high frequency attenuator and low frequency attenuator, together with a gain control.

913

913 — Waste Mobile

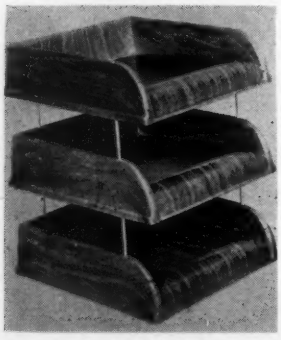
■ THE WASTE MOBILE is a four- or six-bushel bag suspended from a light-weight steel tube frame on full swivel three-inch rubber casters. Speeds the collection of wet or dry wastes and fabrics. Adapts readily to other collecting chores.

914 — Intercom

■ WILL OPERATE with telephones, as well as other company intercoms served by any private two-wire automatic telephone switchboard. As many as eight remote speaker stations can be connected to each unit for intercom service. Incoming calls can be held, so that contact can be made with any of the remote speaker stations.

915 — Letter Trays

■ LIGHT-WEIGHT, plastic trays with woodgrain finish for modern offices. Trays can be tiered in multiple units, in a matter of seconds. Non-skid rubber feet hold the trays in place on desks or files.



915

916 — Credit System

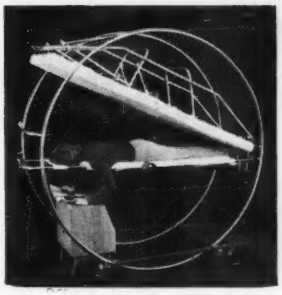
■ KEEPS CHARGE ACCOUNT RECORDS visible for reference. Status of account can be had at once. File is applicable to small hospitals as a simple credit system, which keeps accounts in order and protects the records from fire. The files may be stacked by removing the "snap on" chrome strips on top. Each file holds 120 accounts.

917 — Folding Back Rest

■ THIS back rest may be securely fastened, with strap webbing to any hospital bed. It is made of aluminum tube and canvas; is light and folds flat for storage.

918 — All Purpose Bed

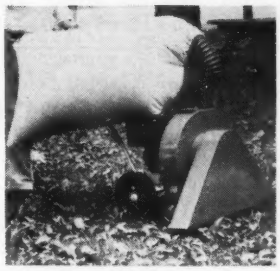
■ WITH THE MANY combinations of manual gatching and electrical tilting of the bed, a wider variation of reclining, sitting and vertical positions are possible. This bed incorporates all the desirable features of regular and special hospital beds. It avoids duplication of equipment for hospital, surgeon and nursing crew. The patient can assume and lock himself in any sitting posture easily and tilt the bed to any angle, including the upright position from which he can walk away.



918

919 — Outdoor Vacuum Cleaner

■ POWERED by a 2¾ horse power gasoline motor, the wheel-mounted cleaner may be used for picking up waste paper, leaves and all types of light trash. The material picked up may be blown directly into inexpensive bags for disposal or it may be blown through an attached flexible tube for deposit into reusable bags, bins or refuse trucks.



919

920 — Flexible Swab Stem

■ The swab is made of flexible, pure white, tightly rolled paper. These swabs can't snap or splinter and give under pressure.

921 — Examining Glove

■ THE GLOVE is so designed that it will fit either left or right hand, completely covering the wrist. It is made with a reinforced flared wrist area for ease in putting the glove on the hand and removing it. The contoured style also permits the flat glove to be opened easily.

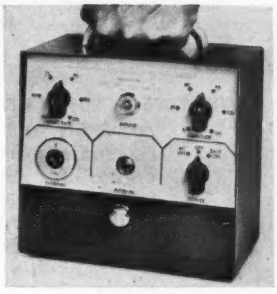
921

922 — Pill Packaging

■ THE PILL PACK is a translucent plastic cup with a printed tab lid. The container holds up to 12 pills. Printed form on the round lid is spaced to allow writing of patient's name, room number and a checkoff of the hour(s) for medication. Self-contained pack with orders reduces the chance of pills being mixed.

923 — Electrodyne Transistor Pacemaker

■ THIS INSTRUMENT is completely portable and miniature in size (only seven inches high). Operating directly from one long life battery, or any standard AC outlet, the instrument may be quickly attached to the patient and, with a flick of the switch, will begin delivering life-saving cardiac stimulation within three seconds.



923

924 — Electric Towel

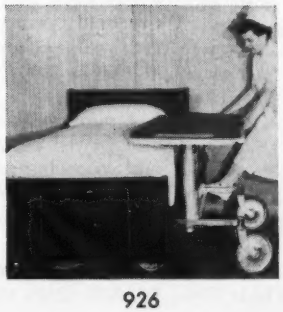
■ THE TOWEL sterilizes the hands as it dries them and a special deodorant block scents both the hands and room with a pleasing fragrance. Through the use of two ozone lamps, its ultra violet radiation kills airborne bacteria.

925 — Insulated Beverage Server

■ THE SERVER is designed to meet the demand for an insulated server for individual table or bedside service. Because of high temperature resistance, boiling drinks may be mixed directly in the server without damage.

926 — Wheel Stretcher

■ HAS AUTOMATIC lowering by touch of pedal, leaving hands free for patient care. Comfortable size, top 26 inches by 74 inches with rubber bumper; extends 10 inches over bed from either side. Within mattress level; hinged side rails with push button release; special designed casters; automatic wheel locks; simple controls.



926

China

Continued from page 129

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Hand painting. Aside from the "art" ware, hand painting is used today, mostly to fill in colors of designs outlined by mechanical means.

Nearly all bands are hand painted and some decalcomanias are made with the idea of touching up by hand. Just as its name implies, this method of decorating is done by the artist with his brush; his finished work being fired to fuse the color into the surface of the ware as is done in the other methods.

Today the user of institutional china has a wide range of patterns and shapes from which to choose. The decorations are usually applied in as economical a way as possible but nevertheless, they are 90 percent applied by hand. This accounts for the difference in price between a decorated and undecorated piece of china. However, the wise operator of an institution or restaurant knows that of all his equipment none comes in closer contact with his guests than the chinaware. It is the package or "frame" that presents his product. It is the one small part of the whole that, if properly and wisely selected, will build good will for him. It is also, regardless of all substitutes, the least expensive method he has to present his food in the most attractive way.

As with anything else, there are many grades of chinaware. The wise operator realizes that as a first consideration he must select the quality china, for by doing so he will have both the proper "frame" for his food and the most economical means of serving his valued guest.

List of American china and semi-vitrified ware manufacturers:

Buffalo	Buffalo, N.Y.
Iraquois	Syracuse, N.Y.
Jackson China Co.	New York, N.Y.
Mayer	Beaver Falls, Pa.
McNichol	Clarksburg, W.Va.
Shenango	New Castle, Pa.
Sterling	East Liverpool, Ohio
Syracuse (Onondaga Pottery Co.)	Syracuse, N.Y.
Technical Porcelain & Chinaware)	El Cerrito, Calif.
Walker China Co.	Bedford, Ohio
Wellsville China	Wellsville, Ohio ■

NEW—economy generating set for hospitals

ALLIS-CHALMERS
G-226
Gas or Gasoline Fuel
35 kw,
3-phase, AC

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ALLIS-CHALMERS

BG-29

Schreiber

Continued from page 122

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Is practically everyone interested in a special case, such as a mother who is still carrying her unborn child after an automobile accident, the mother having had upwards of 70 pints of blood since coming to your hospital? Are there volunteers from your employees to give blood?

And so we go on up the ladder through the Board of Trustees and on up to the President of The Board. Clean-cut decisions well thought out; an alert staff membership; a good word for the other department head; a good joke delivered properly at the right time; friendly smiles that come easily; personal pride in the institution, not just a job. Throw all of these together with many more ingredients and you have MORALE. ■

Mr. Schreiber is the administrator of the Ottumwa (Iowa) Hospital.

BAKED FILLETS OR STEAKS

Portion: 3½ ounces

Ingredients	25 Portions	50 Portions	100 Portions
Fillets or steaks (fresh or frozen)	7 lb. 8 oz.	15 lb.	30 lb.
Grated onion	4 oz. (½ c.)	8 oz. (1 c.)	1 lb. (2 c.)
Salt	4 tsp.	1¼ oz. (2½ tbsp.)	3 oz. (1/3 cup)
Ac'cent	1½ tsp.	1 tbsp.	2 tbsp.
Paprika	1 tbsp.	½ oz. (2 tbsp.)	1 oz. (¼ c.)
Black pepper	¾ tsp.	1½ tsp.	1 tbsp.
Melted butter or other fat	8 oz. (1 c.)	1 lb. (2 c.)	2 lb. (1 qt.)
Lemon juice	4 oz. (½ c.)	8 oz. (1 c.)	1 lb. (2 c.)
Chopped parsley	1 tbsp.	2 tbsp.	¼ c.

1. Thaw frozen fillets or steaks.
2. Divide fillets into serving-size portions, using 4½ ounces as an average weight.
3. Place in a single layer in well-greased baking pans.
4. Add onion, salt, paprika, and pepper to butter. Gradually add lemon juice, beating constantly until blended.
5. Cover fish with the sauce.
6. Bake in a moderate oven, 350 F., for 30 to 40 minutes or until the fish flakes easily when tested with a fork.
7. Sprinkle parsley over the fish.

SHRIMP CREOLE

Portion: ¾ cup of creole; ½ cup of rice

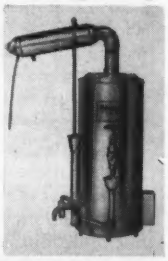
Ingredients	25 Portions	50 Portions	100 Portions
Shrimp (fresh or frozen)	7 lb. 8 oz.	15 lb.	30 lb.
Water	1½ gal.	3 gal.	6 gal.
Ac'cent	1 tbsp.	2 tbsp.	4 tbsp.
Salt	6 oz. (¾ c.)	12 oz. (1½ c.)	1 lb. 8 oz. (3 c.)
Chopped onions	12 oz. (2 c.)	1 lb. 8 oz. (1 qt.)	3 lb. (2 qt.)
Chopped garlic	½ clove	1 clove	2 cloves
Chopped green pepper	10 oz. (2 c.)	1 lb. 4 oz. (1 qt.)	2 lb. 8 oz. (2 qt.)
Melted butter or other fat	4 oz. (½ c.)	8 oz. (1 c.)	1 lb. (2 c.)
Flour	2½ oz. (2/3 c.)	5 oz. (1¼ c.)	10 oz. (2½ c.)
Salt	1½ tbsp.	1½ oz. (3 tbsp.)	3 oz. (1/3 c.)
Pepper	1 tsp.	2 tsp.	4 tsp.
Tomatoes	2½ qt.	5 qt.	2½ gal.
Cooked rice	3 qt. ½ c.	6¼ qt.	3 gal. 2 c.

1. Place shrimp in boiling salted water. Cover and return to boiling point; simmer 5 minutes.
2. Drain, peel, and remove sand veins.
3. Wash.
4. Cook onion, garlic, and green pepper in butter until tender. Blend in flour and seasonings. Add tomatoes and cook until thick, stirring occasionally.
5. Add shrimp; heat thoroughly.
6. Serve a 6-ounce ladle (¾ cup) of creole over a No. 8 scoop (½ cup) of rice.

BARNSTEAD WATER STILLS

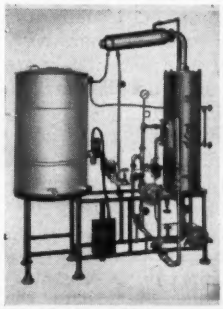
FOR THE LABORATORY

Wherever high purity, pyrogen-free water is a must . . . in the operating room, laboratory, solution room, blood bank, and pharmacy . . . you'll find Barnstead Still as standard equipment . . . the choice of practically all leading hospitals . . . since 1878. Right: Model ELQ-1. Electric. 1 g.p.h.



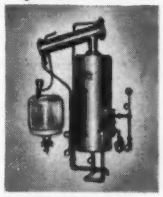
CENTRAL SUPPLY

Barnstead Still and Tank combination with full automatic controls . . . self-starting, self-stopping and self-flushing. No manual attention needed . . . Produces highest purity, pyrogen-free water obtainable . . . year after year. Model SMQ-10. Steam-heated. 10 g.p.h.



PHARMACY

SMQ-15V wall mounted model was designed to meet today's increased demands for distilled water in the pharmacies of larger hospitals. Requires less space . . . costs less because it does the work of several small stills.



WRITE FOR HOSPITAL CATALOG "H"

Barnstead
STILL & STERILIZER CO.

BOSTON JAmaica 4-3100	NEW YORK Kingsbridge 8-1557	CLEVELAND ACademy 6-6622
CHICAGO MUlberry 5-8180	PHILADELPHIA LOcust 8-1796	LOS ANGELES RYan 1-6663
JOHNSON CITY 3113	SAN FRANCISCO TEmplebar 2-5391	CHATTANOOGA 6-5863

Lanesville Terrace, Boston 31, Mass.

FIRST IN PURE WATER SINCE 1878

For more information, use postcard on page 143

China

Continued from page 129

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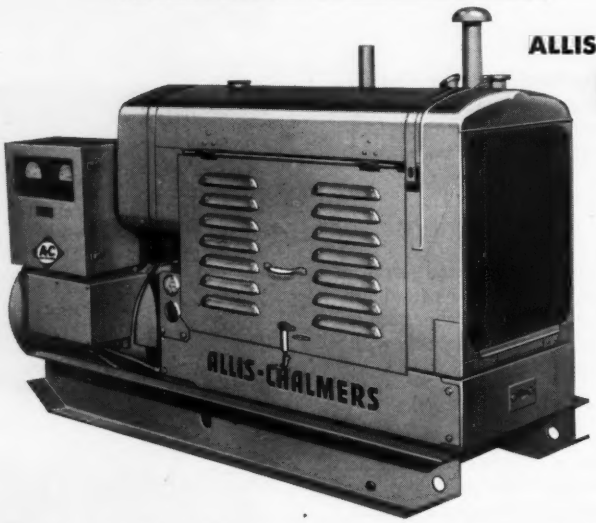

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Salt	1½ tbsp.	1½ oz. (3 tbsp.)	3 oz. (1/3 c.)
Pepper	1 tsp.	2 tsp.	4 tsp.
Tomatoes	2½ qt.	5 qt.	2½ gal.
Cooked rice	3 qt. ½ c.	6¼ qt.	3 gal. 2 c.

1. Place shrimp in boiling salted water. Cover and return to boiling point; simmer 5 minutes.
2. Drain, peel, and remove sand veins.
3. Wash.
4. Cook onion, garlic, and green pepper in butter until tender. Blend in flour and seasonings. Add tomatoes and cook until thick, stirring occasionally.
5. Add shrimp; heat thoroughly.
6. Serve a 6-ounce ladle (¾ cup) of creole over a No. 8 scoop (½ cup) of rice.

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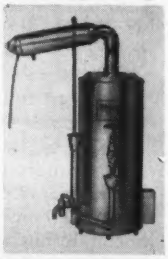
Wherever high purity, pyrogen-free water is a must . . . in the operating room, laboratory, solution room, blood bank, and pharmacy . . . you'll find Barnstead Still as standard equipment . . . the choice of practically all leading hospitals . . . since 1878. Right: Model ELQ-1. Electric. 1 g.p.h.



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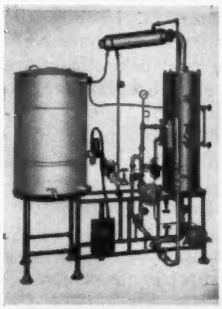

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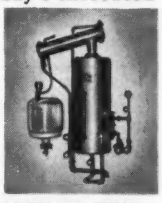
SMQ-15V wall mounted model was designed to meet today's increased demands for distilled water in the pharmacies of larger hospitals. Requires less space . . . costs less because it does the work of several small stills.



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Lanesville Terrace, Boston 31, Mass.

FIRST IN PURE WATER SINCE 1878

Moravec

Continued from page 54

din, head of the Department of Pharmacology of the University of Arkansas School of Pharmacy.

The loose-leaf booklet form of the American Hospital Formulary will have regularly issued supplementary monographs which will keep it contemporary. It will be distributed through the Hamilton Press, Hamilton, Illinois, and will be available in September of this year. The price of the Formulary, which will include the drug monographs, a loose-leaf notebook and supplementary monographs for one year, is as follows:

1-9 copies—$15.00 each
10-24 copies—$14.50 each
25 or more copies—$14.00 each.

This service, in my opinion, is par excellance not only for larger hospitals but is equally as valuable to the smaller ones. What a boon it can be to the hospitals of 100 beds and less where often efficient pharmacy management leaves much to be desired. Often expensive drug inventories are obese and scattered over all the hospital. Usually the medical staffs are comparatively small. So often pharmaceuticals are costing the smaller hospital far too much which in turn reflects very significantly on income required to maintain the financial balance desired of the smaller hospital administrator. It is in such setting that the American Hospital Formulary Service of the American Society of Hospital Pharmacists is a timely and valuable contribution to the hospital world. The tedious, time-consuming and expensive task of compiling hospital formularies will be no longer necessary. Hospitals of all sizes can benefit greatly from this excellent contribution. ■

Moravec

Continued from page 45

Daniel F. Moravec

cooperation not only with the medical staff but with the other department heads as well—all in the interest of the hospitals' patients.

Today, the hospital pharmacy is one of the most important full-fledged departments in the modern hospital. The contemporary hospital pharmacy is a combination of compounding, dispensing, manufacturing and research in the truest sense of the word. It is a workshop that requires a routine application of all the tools, techniques and pharmaceutical knowledge that the student in pharmacy learns before he or she graduates from college.

Hospital pharmacies of today therefore are, by necessity, really an aggregation of retail, manufacturing, academic, research and all phases of the pharmaceutical profession. Organized hospital pharmacy is young with vast areas of challenge facing it. It needs many good young people to help it accomplish the big task it has before it. ■

Verhulst

Continued from page 49

problem of educating parents to keep potentially poisonous materials away from toddlers than the pharmacist. This problem must be solved before the death rate by accidental ingestion of poisons can be greatly decreased, particularly in the one- to five-year-old age group.

Adequate safeguards must be taken in every home to see that all household products, whether they be medications, insecticides, cosmetics or other potentially poisonous products, are kept out of the reach of children. Internal medication should not be placed alongside an external medication or cleaning solution in the medicine chest. You all know how simple it is to reach for one bottle and find another in your hand, and you are professional people who have trained for years to read every label.

At the October meeting of the National Safety Congress held in Chicago, Mr. Victor M. Ratner of the advertising firm of Benton & Bowles prepared comments for a panel discussion. I was deeply interested in one of his statements which I quote:

"All I can say is that, the older I get, the more convinced I become that the only hope of moving serious ideas into peoples heads effectively is for us to set aside the seduction of our modern, technologically advanced, mechanical media—and to refocus our attention on the basic, old-fashioned methods of 'face-to-face communication'.

For this is still the only way in which most people get most of the ideas which move them."

There is one simple thing pharmacists can begin doing immediately that may be effective in an all-out educational program to prevent accidental poisoning. When you fill a prescription for a child or parent or make a sale of a household preparation which is dangerous when ingested, suggest to the purchaser that the item should be kept out of the reach of children.

Parents should also be warned about disposing of old medications by dropping them into a garbage can or other refuse receptacle. This is an open invitation to children to retrieve them. Instruct parents instead to dissolve such medicaments and send them down the drain. Warn them also that all containers in which lyes or other corrosives have been stored should be washed thoroughly with water before discarding.

For those of you who work in a hospital with a treatment center for poisoning, here is a word of advice. Acquaint the operating staff of the treatment center with the pharmacy library and facilities. I was amazed recently when I mentioned to a physician in a center that the pharmacy might have some of the reference material he needed, and he replied that they did but it was not available to him.

The chief pharmacist should check the material which is in the poison treatment center at regular intervals. On a trip through what I consider to be one of the better poison control centers in the country I, through force of habit, picked up a bottle of 5 percent dextrose and inverted it. I was startled to see a precipitate float down through the solution. Here was a unit in which the medical staff operated around the clock to save lives, but the pharmacist apparently did not take ten minutes a month to make sure that their medication was safe for use.

Once an item has been ingested if lives are to be saved, adequate information on the product is a necessary requirement so that proper treatment may be started at once. Making this information immediately available is a task which will require all our efforts—yours and mine. ■

Do You Know the Author?

Dear Doctor Letourneau:

I was surprised but enjoyed reading the item on page 90 of "Hospital Management," January 1958 issue, entitled "A Little Boy's Essay on Anatomy". I picked this item up several years ago; and, to my knowledge, the author is unknown. However, I've read this "essay" to the students attending the American Medical Association's Standard Nomenclature Institutes as an introduction to my lectures on Anatomy and Physiology.

At the past three Institutes, I've read an additional essay, a copy of which is enclosed. Again, I do not know the author. I'm sure that over a thousand students have heard this "essay" read at these Institutes. Probably one of these sent the copy to you because I've often permitted students to copy the essay.

If through the publication of this article, you should be able to find the author, I would appreciate knowing his name as I would like to give credit to him when I read the essay.

Kindest personal regards.

Very truly yours,

Edward T. Thompson, M.D.

Editor
Standard Nomenclature of
Diseases and Operations
American Medical
Association

A Schoolboy's Outline on Anatomy . . .

■ A MAN is shaped something like a monkey, only he stands up on two feet.

The parts that trail on the ground are called feet. They feel better when you put them on something. Feet have toes sticking out of the end of them which have corns sometimes, so you can tell when it is going to rain. The ankles hold the feet onto the legs and they wobble when you feel good—easily get sprained which makes you feel bad. The legs go up from the ankles and have knobs in the middle which fold up when you sit down and get stiff before you get up. They run up to the trunk which has no lid and can only be opened with a knife. This is called an operation when you are alive and an autopsy if you are dead.

The trunk contains among other things the stummick is where you get hungry. Then you eat too much and you are sorry. The walls of the chest are made of ribs and are ticklish. The diaphragm is used for getting hiccoughs and holds up the chest.

The heart is what the doctor counts when he holds your wrist to see what time it is. Your insides are what you should take care of because it is hard to get new ones. The back is behind the front and has a pile of bones stacked up on each other, called backbone. It is attached to the shoulders near the top. The shoulders hold on the arms and hands. The hands on a man always want to pat somebody, and on girl's they are always fussing with hair or getting manicured.

On the shoulder is the neck which gets dirty if it's on a boy and he wears a collar and tie on it when he gets older. A neck on a girl's shoulder often has an arm around it or the skin of another animal. The front of the back of the neck has a Adam's apple, if it's on a man it runs up and down when he talks. The Adam's apple on a girl doesn't count.

On the neck is the head which can be turned in any direction, and gets headaches. On the front of the head is the face which has features such as ears, nose, mouth and eyes. This is the part that looks like you. If two faces look like you it's called twins and costs twice as much to have. Ear muffs keep the ears warm but you can't hear enough that way. The nose is sometimes ornamental as well as useful and often used to get colds in.

The mouth has 32 teeth for a full set, if you are lucky and see your dentist twice a year and he doesn't need the money. The eyes are what you close to keep out the light when you are asleep. The brain is inside the head and is used to think up inventions and stuff and the top is hair, which comes in different colors. It can be curled, parted, brushed, or worn straight back. It can also be worn bald which is too bad, but there is nothing you can do about it.

You cannot measure a person's happiness by the amount of money he has. A man with 10 million dollars may be no happier than the man with 9 million.

MEMO TO: Hospital Administrators

Here is a working tool that belongs in every nursing station, pantry floor, purchasing, stores and all other requisitioning departments.

SAVE THOUSANDS OF DOLLARS YEARLY

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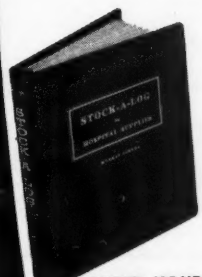

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Miss Elsie Dey, Director

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DIETICIAN: Qualified Dietician required to take charge of an up-to-date Dietary Department of a modern 155-bed hospital. Day shift only, liberal holidays, sick leave, pension plan and excellent working conditions. Salary to commensurate with qualifications. Applicants to give full details of experience, qualifications, age and salary expected. Apply to Superintendent, Swift Current Union Hospital, Swift Current, Sask., Canada.

DIRECTOR OF NURSING SERVICE: 320 bed general hospital; fully approved, Joint Commission, Interns & Residents, School of Nursing. Prefer not over 45, Protestant, Degree, experience in Nursing Service. Salary potential $4,780.00 to $7,072.00 range, fringe benefits substantial. Apply Superintendent, Bethesda Hospital, Cincinnati 6, Ohio.

SUPERVISOR—OBSTETRICAL: New fully approved JCHA 238 bed general hospital, ideal working and living conditions. Close to Estes Park, Denver, and Cheyenne. College town. Starting salary $345.00 per month, social security, liberal fringe benefits. New low rental residence building on grounds. Apply Personnel Office. Weld County General Hospital, Greeley, Colorado.

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SHAY MEDICAL AGENCY
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EXECUTIVE PERSONNEL: (a) Controller-Business Manager. Near Chicago. Good background in hospital accounting. $7800. (HT-3008). (b) Personnel Director. Southwest. 500 bed hospital. (HT-2195). (c) Administrative Assistant. California. Responsible for admitting, accounts receivable and medical record functions. 225 bed teaching hospital. $6000 minimum. (HT-2238). (d) Office manager-Accountant. South. 200 bed hospital. Degree with major in accounting preferred. Will train to take over as administrator as present incumbent is retiring in near future. (HT-2025). (e) Director of Business Management. State Board of Health. Degree in accounting and public health or business administration experience. To $11,000. (HT-2091).

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CHIEF OCCUPATIONAL THERAPIST: Southwest. Experienced in the physical disability areas. To administrate three clinics with five sections consisting of pediatrics, general medicine and surgery, psychiatry, tuberculosis and physical disability. Hospital affiliated with medical school and university. (HT-2198).

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application — a postcard will do. ALL NEGOTIATIONS STRICTLY CONFIDENTIAL.

DIRECTOR OF NURSES—experience preferred; And one general duty nurse, for 40 to 50 bed hospital at Amery, Wisconsin, 60 miles East of St. Paul—Minneapolis. Salary open. Please contact Administrator, Apple River Valley Memorial Hospital, Inc. Amery, Wisconsin.

THERAPEUTIC DIETICIAN: Fine opportunity in progressive organization. 200 bed general hospital. Excellent working conditions; many benefits. Prefer A.D.A.; will consider others. Write or call Personnel Director, Flower Hospital, Toledo, Ohio.

ADMINISTRATOR: To be employed Jan. 1, 1959. 50 bed Hill Burton Hospital. State qualifications, experience and salary expected. **SUMNER COUNTY HOSPITAL COMMISSION**, Sumner County Court House, Gallatin, Tennessee.

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We have splendid openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Staff Nurses. If you are looking for a position, write us.

LIBRARIAN: registered or equal; full charge of department in 45 bed hospital 75 miles east of St. Louis, Missouri. Salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

DIETITIAN: A. D. A. or equal; full charge of department in 45 bed hospital 75 miles east of St. Louis, Missouri. Salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

RADIOLOGIST: Capitol Hospital, Milwaukee, Wisconsin. Contact: Administrator, Capitol Hospital, 1971 West Capitol Drive, Milwaukee 6, Wisconsin. Hilltop 2-9100.

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333 Bulkley Building, Cleveland, Ohio
Miss Elsie Dey, Director

ASSISTANT ADMINISTRATOR: Or Business Manager. B.B.A. Degree, 1953. Completes Residency October, 1958. Previously Office Manager, 3 years.

ADMINISTRATOR: M.S.H.A. Degree, July 1954. Administrative Residency, 300 bed Michigan hospital. 3 years Administrator, 75 bed hospital.

COMPTROLLER: C.P.A. 4 years Auditor; 6 years Executive Accountant, 600 bed Ohio hospital.

PURCHASING AGENT: 10 years' experience. Present position, 300 bed Illinois hospital.

NURSE ADMINISTRATOR: 15 years Director, Nursing Service; 10 years Superintendent, 40-75 bed hospitals. New England considered.

EXECUTIVE HOUSEKEEPER: College education. 8 years experience; desires change.

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MISCELLANEOUS

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Take It Easy . . . . .
But Not Too Easy

by Milton Margolis, M.D.
Milwaukee, Wisconsin

■ "TAKE IT EASY" is one of the most widely used phrases in the United States today and has been for many years.

In the last decade or so, the phrase has been expanded in any number of books—books which tell you how to relax, how to avoid nervous tensions, how to keep from worrying, how to have endless peace of mind, and so on and so forth.

These volumes no doubt have their place in the scheme of things. Just the same, we got a most agreeable jolt the other day when a University of Minnesota Medical School neurology professor named Burtrom C. Schiele told the Associated Press that "tension is a normal, everyday phenomenon for all of us," and "serves a useful purpose in keeping us alert, active and effective."

Overdoing Relaxation

That reminded us of a yarn told by comedian Herb Schriner, about a friend of his who used to drink, so he said, to steady his nerves. His nerves would get a little steadier after the first drink, more so after the second, and so on, until his nerves got so steady that he couldn't move.

It's the same way with relaxation, avoidance of worry, conscious loosening of tensions. Those devices are good up to a point. But you can get so relaxed that you won't do anything, so free of worry that your job will go to pot, so lacking in inner tension that you won't care what happens to you—or, more important, to those dependent on you for support or encouragement or good example.

The main thing, it seems to us, is to make your tensions, worries and nerves work for you instead of against you—to force them to be constructive, not destructive. That way you can hope to keep them from getting you down—just as Jack Dempsey used to make his admittedly great fear of his opponents work for him in the prize ring, instead of against him.

Wasn't it President Theodore Roosevelt who urged what he called "the strenuous life" on his fellow Americans? And didn't T. R. make quite a name for himself as a President, a sportsman, a scholar, a writer, and an all-around man?

It was; and he did. ■

Barnstead Briefs

A column devoted to the latest water purification developments in the hospital

YOUR WATER STILL

The problem of separating gaseous impurities from the final distillate has been solved by Barnstead Engineers: First, the pre-heated water from the condenser is discharged into an open, hot well overflow chamber. Here gases such as CO_2, Chlorine, Ammonia, etc., are discharged before evaporation. Next, the vented 10° inclined condenser separates and expels any last traces of gaseous impurities after evaporation.

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To maintain constant sterility in stored distilled water, the "Hospital Type" distilled water storage tank is a must. Steam coils are mounted in the tank to keep contents constantly sterile. Electric submersion-type heaters are provided where steam is not available. Contamination from the air is prevented by the "Ventgard" air filter. Made of copper and lined with pure block tin, the unit includes self-closing valves, dial-type thermometer, inlet and overflow connections.

OPERATING & MAINTENANCE HINTS

Since the impurities removed from the raw water, concentrate in the evaporator, it is desirable to drain the Water Still each day. This retards the buildup of scale and lessens the needs for cleaning. The evaporator must be filled after draining to prevent the possibility of burnout that may occur when gas and electrically heated stills are turned on without water in evaporator. Automatic low-water cutoffs are available to guarantee against burnouts.

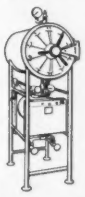
FIELD REPORTS

Barnstead Distilled Water benefits hospitals in many ways. The tested and reliably prepared pharmaceuticals

which a hospitals purchases from outstanding firms often begin with Barnstead Distilled Water. For controlled quality of unvarying purity in the production of antibiotics the Upjohn Company of Kalamazoo, Michigan, depends on a Barnstead SS-50 Still which produces ultra-pure water at the rate of 50 gallons per hour.

WOULD YOU BELIEVE —

According to the U. S. Pharmacopoeia the maximum impurities allowed for distilled water is ten parts per million or 50,000 ohms resistance. Recently, Barnstead developed a method of producing the purest water yet obtainable by using a Water Still, two demineralizers, and a Barnstead MF submicron filter operating in series. The result is pyrogenfree water with resistance of 15,000,000 ohms and the opening up of new scientific frontiers.



NEW PRODUCTS

New Hinged-Door type autoclave added to Barnstead's line of Laboratory Autoclaves. This model features radial locking arms to permit full opening of autoclave door, thus permitting the entrance of larger containers. Constructed of monel metal or stainless steel, it contains a built-in safety device that locks the door handle . . . door cannot be released until pressure in the chamber is gone. All welded rivetless construction with double or single walls. For further information, please write to Barnstead Still & Sterilizer Co., 31 Lanesville Terrace, Boston 31, Mass.

For more information, use postcard on page 143

From the Consultant's Notebook

by **E. M. Bluestone, M.D.**

When a patient wants to leave the hospital prematurely (with the possible exception of the psychiatric patient) you can, as a rule, blame the hospital rather than the patient.

It was in the background of environmental medicine and under the influence of its teachings that the modern extra-mural idea of hospital service (Home Care) was born.

Death is inevitable. This is a biological phenomenon which science will never help us to escape. Hospitals, like human beings, want to know *how* death will come and what we can do to postpone and mitigate it since we cannot restrain its ultimate effect.

•

The administrator who will not face the alternatives involved in taking risks lacks courage; the one who does, and whose batting average in the presence of risks is low, lacks something else (please fill in the quality yourself); and the one who does not use the universality of risks to point up an important hospital lesson breaks faith with the best ideals of hospital public relations.

•

I sometimes think that it might be highly productive for the professor of anatomy to provide every student with the social history of the cadaver which he is about to dissect in preparation for a lifetime of activity in the practice of medicine.

•

This is the question: Under what circumstances in his sick life are we justified in transferring a man out of his individual home into a collective hospital, and at what point should we return him there, assuming that in the interval, we will do all we can to cure him of his illness and influence the environment for the better in which his illness may have been incubated?

•

It is worth noting that slums are made in considerable measure by poor housing and poor sections of the city but *they are mostly made by poor people.* Since hospitals must respond to the call of Environmental Medicine they must bear this in mind.

•

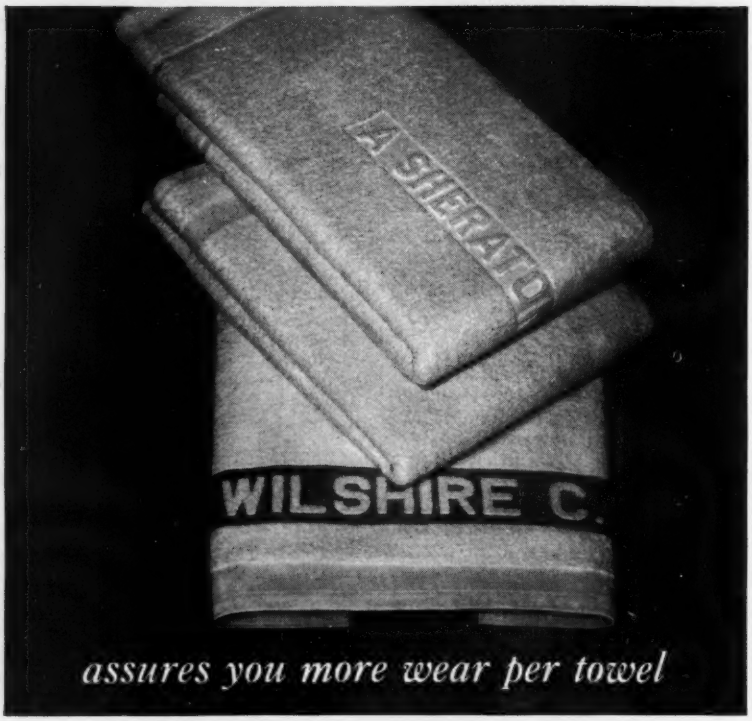
Privacy is not as expensive a commodity as some hospital folk think. And, even if it were, it would be community money well spent.

•

I must put in a good word for accurate figures and statistics based on the laws of logic. They are wonderful tools of work, and very convincing in the hands of patient, honest, and knowledgeable people. They should be placed on the shelf only after spending a reasonable time on the desk. Something of the language of hospital history is in them.

DUNDEE

SUPER-SELVAGE



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